

Medi-Cal Rx Provider Manual

June 1, 2025

Revision History

Date	Description
<i>Updates are visually identified in this manual via symbol and font color: >>updated text. Search for >> to quickly find updated text or select the hyperlinked section number in this Revision History Table to jump to the updated section.</i>	
06/01/2025	<p>The following sections have been updated this month:</p> <ul style="list-style-type: none"> • Section 4.6.18: <ul style="list-style-type: none"> – Updated language. • Section 15.9.1: <ul style="list-style-type: none"> – Updated language. • Section 16.2: <ul style="list-style-type: none"> – Updated language. • Section 17.1: <ul style="list-style-type: none"> – Updated language. • Section 18.1: <ul style="list-style-type: none"> – Updated language. • Section 19.1.1: <ul style="list-style-type: none"> – Updated language.

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1.0 Introduction

The Medi-Cal program objective is to provide essential medical care and services to preserve health, alleviate sickness, and mitigate disabling conditions for individuals or families on public assistance, or whose income is not enough to meet their individual needs. The covered services are generally recognized as standard medical services required in the treatment or prevention of diseases, disability, infirmity, or impairment. These services are comprehensive and provide care in the major disciplines of health care.

From the inception of the Medi-Cal program in March 1966, the State has contracted with a Fiscal Intermediary (FI) to receive and process Medi-Cal claims. Beginning January 1, 2022, the new California Department of Health Care Services (DHCS) FI for Medi-Cal Rx pharmacy services is Prime Therapeutics State Government Solutions LLC (Prime).

1.1 Medi-Cal Rx Pharmacy

This manual provides claims submission guidelines for Providers for the fee-for-service (FFS) Medi-Cal Rx pharmacy programs managed by the Medi-Cal Rx vendor for DHCS.

The pharmacy component of the following programs is a part of Medi-Cal Rx:

- Medi-Cal
- California Children's Services (CCS)
- Genetically Handicapped Persons Program (GHPP)
- Family Planning, Access, Care, and Treatment (Family PACT)

Billing guidelines and information regarding pharmacy claims specified throughout this manual pertain to all pharmacy programs, as do any references to Medicaid/DHCS, unless specifically stated otherwise.

Note: Items billed as medical claims, such as Durable Medical Equipment (DME) and certain disposable medical supplies should be submitted to the California Medicaid Management Information Systems (CA-MMIS) FI or the applicable Managed Care Plan (MCP).

1.2 Medi-Cal Rx Vendor

The DHCS contracts with its Medi-Cal Rx vendor to:

- Adjudicate claims.
- Distribute payment and Remittance Advices (RAs).
- Review PA requests.
- Perform Prospective Drug Use Review (ProDUR) and Retrospective Drug Use Review (RetroDUR).
- Conduct post-payment audits.
- Provide clinical support to pharmacy providers and prescribers seeking coverage details and information.
- Process batch files for claim reimbursement.

- Operate a Medi-Cal Rx Customer Service Center (CSC) for members, pharmacy providers, prescribers, and managed care liaisons.
- Provide Program Integrity functions, which include reviewing, validating, and referring to DHCS identified Fraud, Waste, and Abuse (FWA).

Note: The above list is *not* all-inclusive.

2.0 Billing Overview and Background

2.1 Enrolling as a Medi-Cal Pharmacy Provider

Providers rendering services to Medi-Cal members must be enrolled as Medi-Cal providers by DHCS. To enroll, refer to the *Provider Enrollment Contact Information* table in [Section 2.1.2 – Provider Application and Validation for Enrollment and Provider Enrollment Division Information](#).

The DHCS Provider Enrollment Division (PED) is responsible for the timely enrollment and re-enrollment of eligible Medi-Cal FFS health care providers. The DHCS PED assists providers as follows:

- Accepts and verifies all applications for enrollment.
- Enrolls each provider using a National Provider Identifier (NPI).
- Maintains a Provider Master File (PMF) of provider names and addresses.
- Updates the enrollment status of providers for Medi-Cal records.

2.1.1 Participation Requirements

Provider requirements for providers approved for participation in the Medi-Cal program include:

Federal Laws and Regulations, Welfare and Institutions Code, and California Code of Regulations

Compliance with the Social Security Act (*United States Code*, Title 42, Chapter 7); the *Code of Federal Regulations*, Title 42; the *California Welfare and Institutions Code* (W&I Code) Chapter 7 (commencing with Section 14000) and, in some cases, Chapter 8; and the regulations contained in the *California Code of Regulations* (CCR), Title 22, Division 3 (commencing with Section 50000), is periodically amended.

Record Keeping

Providers must keep necessary records pursuant to CCR, Title 22, Section 51476.

Nondiscrimination

Providers must not discriminate against any member based on sex, race, color, religion, ancestry, national origin or ethnic group identification, age, physical or mental disability, medical condition, genetic information, marital status, or sexual orientation.

2.1.2 Provider Application and Validation for Enrollment and Provider Enrollment Division Information

The Provider Application and Validation for Enrollment (PAVE) Provider Portal is a secure, web-based Provider Portal that simplifies and accelerates enrollment processes. Providers accessing PAVE can complete and submit new enrollment applications, report changes to existing enrollments, and respond to Provider Enrollment Division (PED) initiated requests for continued enrollment or revalidation. To access PAVE, use the following link:

<https://pave.dhcs.ca.gov/sso/login.do>.

PED is responsible for the enrollment and re-enrollment of Medi-Cal FFS health care service providers. PED is also responsible for developing enrollment policy and updating and maintaining provider information in the PMF database that is used in the claims payment process. To access PED, use the following link:

<https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx>.

Additional enrollment information can be found at the following link:

<https://mcweb.apps.prn.cammiis.medi-cal.ca.gov/references/provider-enrollment>.

In addition to the information above, refer to *Table 2.1.2-1* for further available resources:

Provider Enrollment Contact Information	
For: <ul style="list-style-type: none">• Clarification of Enrollment Requirements• Explanation of Application Denial• Medi-Cal Provider Enrollment Process• Revalidation/Re-Enrollment	PED Message Center <ul style="list-style-type: none">• Telephone Number: (916) 323-1945• Online Inquiries: https://www.dhcs.ca.gov/provgovpart/Pages/PED.aspx – select Inquiry Form under “Provider Resources”• Address: Department of Health Care Services Provider Enrollment Division MS 4704 P.O. Box 997412 Sacramento, CA 95899-7412
For: <ul style="list-style-type: none">• PAVE Technical Issues• PAVE Internet Browser Compatibility• PAVE Log-On• System Navigation/Functionality• Uploading/Accessing Documents	PAVE Technical Support <ul style="list-style-type: none">• Website: https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx• Telephone Number: (866) 252-1949• Hours of Operation: Monday-Friday 8 a.m. – 6 p.m. PT, excluding holidays

Table 2.1.2-1: Provider Enrollment Contact Information

2.1.3 Provider Guidelines

2.1.3.1 Change of Pay-To and/or Mailing Address

A change of pay-to address, mailing address, telephone number, or status must be submitted using the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>).

Providers who have changed their pay-to address, mailing address, status, or any other related information must notify the DHCS PED.

Pharmacy providers reporting changes should consider whether the change requires the Board of Pharmacy (BOP) to issue a new Pharmacy Permit. The BOP can be contacted at 1-916-518-3100. If the change requires the BOP to issue a new Pharmacy Permit, the pharmacy provider is required to complete a new application using the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>). If a new Pharmacy Retail Permit is *not* required as a result of the change being reported, the Pharmacy provider is required to submit a supplemental change application (refer to [Section 2.1.3.2 – Enrollment Information](#)) with the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>).

2.1.3.2 Enrollment Information

In response to fraud and abuse within Medi-Cal, DHCS has adopted regulations governing provider enrollment to ensure program integrity. These regulations require the submission of consistent information that can be used to verify the identity and qualifications of individuals and groups requesting Medi-Cal Rx provider status and establish requirements for the enrollment of most noninstitutional providers who submit FFS claims.

The following types of providers are **not** impacted by these regulations:

- Institutional providers.
- Other Providers licensed or certified by the California Department of Public Health (CDPH).

Medi-Cal Supplemental Changes

DHCS must have current provider information. It is the responsibility of the provider to report any changes in information to DHCS **within 35 days** of the change. Deactivation of the provider billing number will occur if DHCS is unable to contact a provider at the last known pay-to, business, or mailing address. DHCS has developed the supplemental change application that must be submitted using the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>) to report the following changes, additions, or actions:

- Pay-to address, mailing address, or phone number changes.
- Managing employee.
- Pharmacist-in-charge if the provider is a pharmacy.
- Name under which the provider or provider group is doing business as (DBA).
- CLIA number.
- Providers can disenroll through PAVE.
- The days and/or hours of operation of the applicant's or provider's business.

- A change of less than 50 percent in the person(s) with an ownership or control interest, as described in CCR, Title 22, Section 51000.40, of the provider, or provider group that does not result in a new Taxpayer Identification Number (TIN) being issued by the IRS. Any cumulative change of 50 percent or more in the person(s) with an ownership or control interest since the information provided in the last complete application package was approved for enrollment, requires a new application required pursuant to CCR, Title 22, Section 51000.30(b)(6).
- Specialty Code.

2.1.3.3 Enrollment Applications

Change of Ownership or Control Interest of 50 Percent or More

Providers must submit a new enrollment application with PED via the PAVE Portal if the provider undergoes a change of 50 percent or more in ownership or control interest within 35 days of the change of ownership.

Reporting Additional Business Locations

Providers or provider groups that want to submit claims for services rendered at an additional business address are required to submit an enrollment application with PED via the PAVE Portal, as applicable to the provider type. A new application must be submitted via the PAVE Portal for each additional location.

Application Deficiencies

Applicants are allowed 60 days to resubmit their corrected application when DHCS returns it due to deficiencies.

If an applicant fails to resubmit the application to DHCS within 60 days, or fails to remediate the deficiencies identified by DHCS, the application shall be denied. Applicants denied for failure to resubmit in a timely manner or for failure to remediate may re-apply at any time.

Adding Rendering Providers to a Provider Group

Rendering providers are required to submit their applications via PAVE.

For additional information regarding the types of providers considered to be *rendering providers*, including information on licensing and required documents go to the following website:

<https://www.dhcs.ca.gov/provgovpart/Pages/RenderingProviderApplicationInformation.aspx>.

Rendering providers in good standing may join existing provider groups. The group may begin billing for the services delivered by an already enrolled rendering provider by affiliating with the rendering provider via the PAVE Portal. Rendering providers need to apply to Medi-Cal only once but must affiliate with each subsequent group they work for via the PAVE Portal. To initially enroll as a rendering provider, the applicant needs to submit a complete application package to PED via the PAVE Portal on the DHCS website

(<https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx>).

How to Apply for Enrollment or Submit Supplemental Changes via the PAVE Portal

To submit enrollment and supplemental applications, providers can access the PAVE Portal on the DHCS website (<https://www.dhcs.ca.gov/provgovpart/Pages/PAVE.aspx>).

How to Obtain Enrollment and Supplemental Changes Forms

Changes previously reported on the *Medi-Cal Supplemental Changes* (DHCS 6209) form must now be reported via the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>), paper forms are no longer accepted.

2.1.3.4 Obligations to Members

Eligibility Verification Obligates Provider to Render Services

When a provider elects to verify a member's Medi-Cal eligibility, the provider has agreed to accept an individual as a Medi-Cal patient once the information obtained verifies that the individual is eligible to receive Medi-Cal benefits. The provider is then bound by the rules and regulations governing Medi-Cal once a Medi-Cal patient has been accepted into the provider's care.

After receiving verification that a member is Medi-Cal Rx eligible, a provider cannot deny services because:

- The member has other health insurance coverage in addition to Medi-Cal. Providers must not bill the member for private insurance cost-sharing amounts such as deductibles, coinsurance, or copayments because such payments are covered by Medi-Cal up to the Medi-Cal maximum allowances. Providers are reminded that Medi-Cal is the payer of last resort. Medicare and Other Health Coverage (OHC) must be billed prior to submitting claims to Medi-Cal.
- The member has both Medicare and Medi-Cal Rx. Providers must not treat the member as if the member is eligible only for Medicare and then collect Medicare deductibles and coinsurance from the member, according to a 1983 United States District Court decision, Samuel v. California Department of Health Services.
- The service requires the provider to obtain authorization.

Circumstances that Exempt Providers from Rendering Services

A provider may decline to treat a member, even after eligibility verification has been requested, under the following circumstances:

- The member has refused to pay or obligate to pay the required Share of Cost (SOC).
- The member has only limited Medi-Cal Rx benefits and the requested services are not covered by Medi-Cal Rx.
- The member is required to receive the requested services from a designated health plan. This includes cases in which the member is enrolled in an MCP or has private insurance through a Health Maintenance Organization (HMO) or exclusive provider network, and the provider is not a member provider of that health plan.
- The provider cannot render the particular service(s) that the member requires.

- The member is not eligible for Medi-Cal Rx for the month in which service is requested.
- The member is unable to present corroborating identification with the Benefits Identification Card (BIC) ID to verify that he or she is the individual to whom the BIC was issued.

Payment From Members

When Medi-Cal Rx eligibility has been verified, providers must submit a claim for reimbursement according to the rules and regulations of Medi-Cal Rx. Provider must not attempt to obtain payment from members for the cost of Medi-Cal Rx covered health care services. Payment received by providers from DHCS in accordance with Medi-Cal Rx fee structures constitutes payment in full.

Provider Billing after Member Reimbursement

For information about billing Medi-Cal Rx after reimbursing the member, refer to [Section 19.6 – Member Reimbursement Claims](#).

Non-SOC Payments Must be Refunded

Unless it is used to satisfy an SOC requirement, any payment received from a Medi-Cal Rx member must be refunded upon receipt of a Medi-Cal Rx RA reflecting payment for that service.

2.1.3.5 Electronic Claim Submission

Providers may submit claims to the Medi-Cal Rx vendor via telecommunications and other electronic media in the manner and format approved by California W&I Code, Section 14040. Regulations for participation are located in CCR, Title 22, Section 51502.1.

Participation as a Web Claims submitter/Direct Data Entry submitter is open to most Medi-Cal Rx providers, assuming submitted claims are in an acceptable format.

To obtain approval to submit claims electronically through the Medi-Cal Rx vendor, providers must enroll via UAC (refer to [Section 3.6.1.2 – Secured Provider Portal](#)).

2.1.3.6 DHCS and Provider Tax Reporting Responsibilities

Introduction

DHCS is required by Federal Regulation, Section 3406 of the *Internal Revenue Service (IRS) Code*, to report the amount of payments made to providers and the provider name/Taxpayer Identification Number (TIN) combination associated with these payments using *Form 1099-MISC*. DHCS will only issue the *Form 1099-MISC* on total amount RA reimbursements greater than or equal to \$600 per NPI.

Form W-9

DHCS sends a letter of notification and a copy of *Form W-9* to providers reported by the IRS as having an invalid name/TIN combination. An invalid name/TIN combination occurs when a provider enrolls in Medi-Cal Rx with a TIN that the IRS shows as belonging to another person;

for example, "Fred Jones," enrolls in Medi-Cal Rx with a TIN that the IRS shows as belonging to "Bob Smith."

If providers do not furnish DHCS with a completed *Form W-9* by the date indicated on the notice, DHCS is required to withhold 31 percent of the provider's payments until a W-9 is received. These withheld amounts are forwarded to the IRS, and the provider must work with the IRS to receive any refunds through justification requests. To expedite the correction, providers should include a copy of the IRS payment coupon, or other document from the IRS, that displays both the provider's name and TIN.

To prevent any withholding action, providers must return a completed and signed *Form W-9* to the appropriate address on the notice. The notification letter must accompany the W-9 to ensure credit to the correct provider number. Substitute forms will not be accepted.

Common TIN Errors

The following section outlines some of the most common mistakes that cause invalid TIN information.

Name Changes

Providers change their business name and fail to notify DHCS. Because DHCS is still using the old name, the new name will cause a mismatch with IRS records. Providers must notify DHCS if their business name changes. Because multiple business name changes indicate an ownership change, providers must be prepared to demonstrate that there has been no ownership change. However, if there has been a change, a new provider number will be issued with an application.

Social Security Numbers (SSN)

SSN errors can occur when a provider who is a partnership, corporation, hospital, or clinic is using an individual provider's SSN. In this situation, the Employee Identification Number (EIN) of the partnership, corporation, hospital, or clinic should be used. Providers should only use an SSN with an individual's name. SSN errors can also occur if the provider is an individual provider who should be using their own SSN, but instead the provider is using the EIN of the partnership, corporation, hospital, or clinic of which he or she is a member. Providers should always use their SSN in combination with their name.

EIN Mix-Ups

EIN mix-ups occur when the provider is an operating unit of a larger business entity, and the operating unit is using its own name with the larger business entity's EIN. This will cause a mismatch with IRS records. In this case, operating units should apply for their own EIN or use the name of the larger business entity. Mix-ups also occur when the provider is identifying the business with initials instead of their complete name, as recorded with the IRS. This will cause a mismatch of the provider's name and EIN with IRS records. Providers should use their complete name as recorded with the IRS.

Doing Business As (DBA)

DBA errors can occur when the provider is a sole owner using their DBA name with their SSN or EIN of sole ownership. A sole owner must always put their name first; the DBA name may be listed second.

Change of Ownership

Change of ownership errors can occur when the provider's business has changed ownership and the provider failed to notify DHCS. Since DHCS is still using the TIN and name of the previous owner, this will cause a mismatch with IRS records. Providers must notify DHCS when their business has changed ownership.

IRS Contacts

The second page of the *Form W-9* gives more specific instructions about the name of the TIN that should be submitted to DHCS in accordance with IRS reporting requirements. For more information about TINs, call the IRS at 1-800-829-1040. If you need more information about how to apply for a TIN, call the IRS at 1-209-452-4010, Monday through Friday, 6 a.m. to 6 p.m. For more information about SSNs, contact your nearest Social Security Administration district office.

2.1.3.7 Inactivated Providers

Introduction

DHCS conducts a periodic inactivation of pharmacy providers who no longer bill Medi-Cal Rx. Providers who receive Medi-Cal Rx bulletins with their provider number on the mailing label, but who have discontinued billing Medi-Cal Rx and have not received a payment during the last 12 months, may have their provider number inactivated.

Exceptions

Providers who are located where Medi-Cal Rx is administered by a prepaid health program directed by the county are exempt from periodic inactivation.

Inactivation for Returned Mail

DHCS regularly inactivates providers when their mail (including Medi-Cal Rx checks) is returned by the post office as undeliverable. Therefore, providers who have changed their service and/or pay-to-address, or any other related information, should notify DHCS DATA Unit.

Inactivation Benefits

Periodic inactivation reduces:

- Payment errors such as sending a payment to the wrong provider because the provider number entry is incorrect.
- The cost of handling return mail from providers who are no longer in business at the address indicated on the PMF.

Reactivation Procedures

If a provider number has been inactivated but the provider wants to return to participating in Medi-Cal Rx, information on the PMF must be updated. Providers wishing to reactivate their provider number must complete a provider-specific Medi-Cal Rx enrollment application indicating their provider number and send it to DHCS DATA Unit.

2.1.3.8 Terminating Participation

Voluntary Provider Termination

Providers may terminate their participation with Medi-Cal Rx at any time. Providers who wish to voluntarily terminate their participation are required to request deactivation via the PAVE Portal (<https://pave.dhcs.ca.gov/sso/login.do>).

2.1.4 Provider Guidelines: Billing Compliance

Pursuant to CCR, Title 22, Section 51172, if a prescription has not been received by the member or the member's representative within 15 days of the fill date, the pharmacy must reverse the claim and refund the payment to DHCS.

2.1.4.1 Medi-Cal Provider Fraud, Waste, and Abuse

The Program Integrity/Special Investigations Unit (PI/SIU) is responsible for reviewing, validating, and referring suspected FWA to DHCS under the terms of the Medi-Cal Rx Contract. Medi-Cal Rx takes allegations of fraud very seriously and expects providers to adhere to all Medi-Cal policies, including those related to Program Integrity. Providers suspected of abusing Medi-Cal Rx should be reported to Medi-Cal Rx through the following avenues listed in *Table 2.1.4.1-1*:

Avenues for Communicating Compliance Concerns and Suspected FWA		
Department	Methods	Hours
Medi-Cal Rx PI/SIU	Medi-Cal Rx specific FWA Hotline: (1-800-375-1251, TTY 711) Emails to: FraudTipHotline@primetherapeutics.com	Staffed live by Medi-Cal Rx SIU Specialists Monday – Friday, 8 a.m. to 6 p.m. PT. Voicemail available on corporate holidays; Monday – Friday, 6 p.m. to 8 a.m. PT; and Friday, 6 p.m. to Monday, 8 a.m. PT.
	Referrals sent to PI/SIU physical address via USPS, FedEx, or other delivery service: Medi-Cal Rx PI/SIU 11000 White Rock Rd Rancho Cordova, CA 95670	

Avenues for Communicating Compliance Concerns and Suspected FWA		
Department	Methods	Hours
Prime Therapeutics Special Investigations Unit (SIU)	Emails to: FraudTipHotline@primetherapeutics.com Prime Therapeutics SIU Pharmacy FWA Hotline: (1-800-731-3269)	Hours of Operation: Voicemail available 24 hours a day, 7 days a week, 365 days a year.
	Referrals sent to SIU physical address via USPS, FedEx, or other delivery service: Prime Therapeutics ATTN: Pharmacy Audit & SIU 2900 Ames Crossing Road Eagan, MN 55121	
Compliance	Prime Therapeutics Compliance Department: (1-612-777-5523) Emails to the Prime Therapeutics Compliance Department: Compliance@primetherapeutics.com Emails to the Medi-Cal Rx Compliance Department: MediCalRxCompliance@primetherapeutics.com Anonymous Reporting: Calls to the 24-hour Anonymous Compliance Hotline: (1-800-474-8651) Anonymous emails to the Prime Therapeutics Compliance Department: Reports@lighthouse-services.com www.lighthouse-services.com/prime	The Compliance Hotline is available 24 hours a day, 7 days a week. All Medi-Cal Rx calls reported through the Compliance Hotline are routed to the Medi-Cal Rx Compliance Officer for investigation and/or triage to the appropriate team.
Customer Service	Calls to the Medi-Cal Rx Customer Service Center (CSC): (1-800-977-2273)	Customer Service Representatives (CSRs) are provided with training and procedures on identification and reporting of suspected FWA to PI/SIU.

Table 2.1.4.1-1: Avenues to Communicate FWA

2.1.4.2 Suspended and Ineligible List

Suspension by DHCS

DHCS may terminate the participation of a provider through suspension in accordance with the regulations contained in W&I Code Section 14123 and CCR, Title 22, Chapter 3, Article 6, commencing with Section 51452.

Suspended and Ineligible Provider List

On occasion, providers are suspended or determined ineligible to participate in Medi-Cal Rx (refer to [Section 6.0 – Service Provider \(Pharmacy ID\) and Prescriber ID](#) and [Section 7.0 – Provider Procedure/Drug Code Limitation \(P/DCL\)](#) for information on claim denials for Sanctioned Providers). The [Suspended and Ineligible Provider List](#) (S&I List) is available on the Medi-Cal website.

2.2 Important Contact Information

Refer to [Appendix B – Directory](#) at the end of this manual for important phone numbers, mailing address, and websites.

3.0 Service Support

3.1 Customer Service Center (CSC)

The CSC is available 7 days a week, 24 hours a day, and 365 days per year excluding approved holidays.

Pharmacies, prescribers, members, MCP representatives, and other interested parties can access the CSC via:

- Toll-Free Telephone: 1-800-977-2273

Nationwide Toll-Free Number 1-800-977-2273	Main Menu Options
	For Beneficiaries, press 1
	For Pharmacies, press 2
	For Prescribers, press 3
	For authorized MCP representatives, press 4
	For TTY, press 7
	All other callers, press 8

- Live Chat Channel
 - Chat channel can be accessed through the [Medi-Cal Rx Web Portal](#) (for unsecured chat) or through the [Medi-Cal Rx Provider Portal](#) (for secured chat).

- Email
 - Email channel can be accessed through the [Medi-Cal Rx Provider Portal](#).

Note: The CSC will also be able to assist Portal users with user lock out and/or password reset assistance, provide web support for inquiries regarding Portal navigation, and help with links or questions/concerns with the email/chat channel(s).

Examples of available assistance include, but are not limited to:

- Member inquiries related to:
 - Eligibility
 - **Note:** For members dually enrolled in Medicaid and Medicare and for questions about Medicare-covered benefits, members and Providers will be directed to 1-800-Medicare or to the help desk of the enrolled Medicare Part D prescription drug plan.
 - Benefits/coverage
 - Pharmacy locations
 - Reimbursements (Conlan claims)
 - SOC obligations
 - Privacy rights
- Provider, or MCP representative inquiries related to:
 - Member eligibility
 - PA requests
 - Status of previously submitted PA requests
 - Reasoning of PA request decisions
 - Assistance in resolving denied PA requests
 - Pharmacy claims
 - Claim reimbursement/payment status
 - Checkwrite/Financial inquiries (limited to pharmacy claims)
 - **Note:** Finance CSRs will be available Monday-Friday 8 a.m. to 5 p.m. PT. Voicemail will be available for after-hours inquiries and will be returned on the next business day.

Refer to [Appendix B – Directory](#) at the end of this manual for important phones numbers, addresses, and hours of operations for the CSC.

3.2 Software Vendor Certification

The Software Vendor/Certification Number (NCPDP Field# 110 – AK) of the Transaction Header Segment is required for claims submission under the NCPDP Version D.0; providers should submit the value that is assigned to them when being certified. Certifications occur when the industry moves to a new version of the software such as NCPDP V3.2 to NCPDP V5.1 and then NCPDP V5.1 to NCPDP VD.0. When the next named NCPDP version is announced, the Medi-Cal Rx vendor will certify, through testing, the readiness of the pharmacy system.

For assistance with software vendor certification, contact the Medi-Cal Rx vendor's CSC (1-800-977-2273).

3.3 Electronic Funds Transfer (EFT), Checkwrite Schedule, and Remittance Advices (RAs)

Providers enrolled in Medi-Cal Rx will have the ability to access the [Medi-Cal Rx Secured Provider Portal](#) to request payment preferences. Choices include:

- Receiving paper check or Electronic Funds Transfer (EFT).
- Updating banking information including account and routing numbers.
- Receiving paper remittance or electronic HIPAA compliant 835 remittance file.
- Receiving paper or online download of 1099s (the PDF will be available on the Medi-Cal Rx Secured Provider Portal).
- Designating more than one receiver for RAs.

Notes:

- If no designations are selected, payments, RAs, and 1099s shall all default to paper and will be mailed.
- Choices can be applied or changed at any time by utilizing the [Medi-Cal Rx Provider Portal](#).

3.3.1 Electronic Funds Transfer (EFT)

An EFT payment option is available to all eligible Medi-Cal Rx providers. The EFT allows providers the option of receiving payments via direct deposit, eliminating the need for paper checks.

Note: Providers have the ability to opt out of EFT and return to paper checks at any time. The request will be processed on the next upcoming checkwrite.

To request EFT, a pharmacy must complete the *Electronic Transfer Authorization Form* available on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information**. The Medi-Cal Rx Provider Portal will allow users to submit EFT applications and view or update existing EFT information.

To request EFT via a paper application, go to the [Medi-Cal Rx Provider Portal](#) and select **Forms & Information**. Completed paper EFT applications should be forwarded to the Medi-Cal Rx vendor (refer to [Appendix B – Directory](#) for mailing address). Providers with questions regarding EFTs can call the Customer Service Center (CSC) at 1-800-977-2273.

3.3.2 Checkwrite Schedule

The weekly claim adjudication cycle will commence on Thursday at 12:00 a.m. concluding on Wednesday at 11:59 p.m.

Checkwrite processing for the adjudication week shall occur over the next two weeks with payments and remittances released the third Friday. Holiday weeks may delay payment release dates. The annual checkwrite release calendar shall be available on the [Medi-Cal Rx Provider Portal](#) for providers.

To view the annual checkwrite calendar, go to the Medi-Cal Rx Provider Portal and then select **Forms & Information**.

3.3.3 Remittance Advice (RA)

The Medi-Cal Rx vendor provides the HIPAA ANSI X12 835, Version 5010 A1 Electronic Remittance Advice (ERA), delivered electronically or by mail for the paper RA documents. The ERA/RA lists pharmacy provider's claims adjudicated during a given time frame as outlined in [Section 3.3.2 – Checkwrite Schedule](#). The ERA/RA delivery coincides with the Medi-Cal Rx Payment Release Date.

The Medi-Cal Rx-provided ERA/RA is used by pharmacy providers to reconcile their records with claims that have been paid, reversed, or denied. The ERA/RA is provided weekly by Medi-Cal Rx checkwrite streams in which claims submitted by the pharmacy provider were adjudicated. The Medi-Cal Rx checkwrite streams are Abortion, Medi-Cal, CCS, GHPP, and State Children's Health Insurance Program (SCHIP). Pharmacy providers receive a separate payment for each Medi-Cal Rx checkwrite stream in which claims were adjudicated and a net payment was determined.

To request ERAs, a pharmacy provider must complete an ERA Authorization Agreement. The agreement may be submitted two ways:

1. The pharmacy provider may log in to the [Medi-Cal Rx Secured Provider Portal](#) and select **Finance Portal** from the left-hand menu to access the ERA information page and the ERA Authorization Agreement.
2. The pharmacy provider may complete and mail the *Medi-Cal Rx Electronic Remittance Advice (ERA) Authorization Agreement Form* (DHCS 6550) by going to the [Medi-Cal Rx Provider Portal Forms & Information](#) page. DHCS 6550 forms are mailed to the Medi-Cal Rx vendor (refer to [Appendix B – Directory](#) for mailing address).

While completing the ERA Authorization Agreement (by either method), the pharmacy provider may also identify others they want to allow access to their ERAs; these selected others are known as Receivers. The ERA and Receiver information can be updated, by the pharmacy

provider, at any time by either of the methods described. Pharmacy providers with questions regarding ERA Authorization Agreements may call the Customer Service Center (CSC) at 1-800-977-2273.

ERAs are directly delivered through the Medi-Cal Rx Secured Provider Portal. Once logged in to the Medi-Cal Rx Secured Provider Portal, the pharmacy provider and designated Receivers are able to download the HIPAA-compliant 835 file to their preferred application, or they are able to view and print from a CMS-provided Medicare Remit Easy Print (MREP) Software tool.

Note: The MREP tool can be downloaded from the Medi-Cal Rx Provider Portal [Forms & Information](#) page.

ERAs are produced weekly in coordination with the Medi-Cal Rx payment release schedule. They may appear a day or two prior to the payment release date.

If the pharmacy provider has not opted in for ERAs, a paper RA is mailed to the provider's Pay To address that is on file with the DHCS PED. To update the pay-to address on file with PED, the pharmacy provider needs to utilize the [PAVE Portal](#). In addition to the mailed paper RA, the pharmacy provider can access a soft-copy PDF document once they are logged in to the [Medi-Cal Rx Provider Portal](#).

Refer to *Section 3.3.3.1 – Paper RA Example* for an explanation of form fields and sample reimbursement data for Medi-Cal Rx claims. The mailed paper RA is a two-sided, 8½ x 11-inch document.

3.3.3.1 Paper RA Example

A paper RA details the pharmacy provider's adjudicated claim and Accounts Receivable (AR) activity for a given checkwrite stream.

Remittance Fields and Descriptions

Refer to *Table 3.3.3.1-1* below for the paper RA field descriptions.

RA Field	Description
Each NPI/Owner Remittance Shall Contain the Following:	
Payee	Pharmacy provider's legal name and pay-to address
Payee No.	10-digit NPI plus 2-digit owner number
Run Date	Date RA is printed
Page	Page number and total pages (page 1 of...)
Checkwrite Program	Checkwrite stream: Medi-Cal, SCHIP, Abortion, CCS, GHPP, OPH
Check/EFT Number	Check or EFT number
Check/EFT Date	Medi-Cal Rx payment release date
Rx Number	The prescription number as assigned by the pharmacy or the Medi-Cal Rx-assigned AR number for an AR transaction

RA Field	Description		
Each NPI/Owner Remittance Shall Contain the Following:			
Date Filled	Date of service (DOS) for the claim or the AR open date for an AR transaction		
Last Name	Member’s last name as submitted on the claim		
First Name	Member’s first name as submitted on the claim		
Beneficiary ID Number	Member’s Medi-Cal ID number as submitted on the claim		
National Drug Code	The NDC as submitted on the claim; for compound claims, this field will contain the first ingredient submitted on the claim		
Drug Name	Drug name for the NDC on the claim or AR description for an AR transaction		
Refill	The refill number as submitted on the claim		
Qty	The dispensed quantity of the drug as submitted on the claim		
Amount Billed (\$)	The gross amount due (GAD) (NCPDP 430-DU) from the submitted claim (as recommended by NCPDP). Refer to <i>Figures 3.3.3.2-1</i> and <i>3.3.3.2-2</i> for sample RAs. Prior to September 12, 2023: The Usual and Customary Charge (NCPDP 426-DQ) amount from the submitted claim.		
Amount Allowed (\$)	The Medi-Cal Rx-allowed amount for the claim as determined during adjudication per Medi-Cal Rx reimbursement methodology		
Amount Deducted (\$)	The amount deducted for payment reductions as determined during adjudication per Medi-Cal Rx reimbursement methodology		
Amount Paid (\$)	The final claim reimbursement amount or AR payment/recoupment amount		
Claim Type	Claim Type Code or AR transaction type code value assigned to the account activity. The Claim Type Code Description is provided for reference.		
		Claim Type Code	Claim Type Code Description
	1.	MA	Mass Adjustment Claim
	2.	POS	POS Claim (POS = Point-of-Sale)
	3.	01B	Payment Suspension
	4.	02A	Cash Advance
	5.	02M	Audits & Investigations
	6.	02N	Negative Balance

RA Field	Description		
Each NPI/Owner Remittance Shall Contain the Following:			
	7.	02S	HMS * Audit (Recovery)
	8.	02Y	Conlan
	9.	08L	Lien/Levy Withholds
	10.	08T	IRS Withholds
	* Health Management Systems, Inc. (on behalf of DHCS TPLRD)		
PA Flag	"Y" (Yes) or "N" (No) to indicate if a PA was on file and was used to adjudicate the claim		
Error Code	NCPDP-compliant reject (denial) codes		
Totals	Total transaction count		
Subtotal	Total dollars for "Amount Billed," "Amount Allowed," "Amount Deducted," and "Amount Paid" fields		
Legends			
Error Code	NCPDP reject (denial) code value		
Description	NCPDP reject (denial) code description		
Claim Type	Claim Type Code or AR transaction type code value assigned to the account activity. The Claim Type Code Description is provided for reference.		
		Claim Type Code	Claim Type Code Descriptions
	1.	MA	Mass Adjustment Claim
	2.	POS	POS Claim (POS = Point-of-Sale)
	3.	01B	Payment Suspension
	4.	02A	Cash Advance
	5.	02M	Audits & Investigations
	6.	02N	Negative Balance
	7.	02S	HMS Audit (Recovery)
	8.	02Y	Conlan
	9.	08L	Lien/Levy Withholds
	10.	08T	IRS Withholds
Description	Claim Type Code or AR transaction type code description		
Transaction Summary Section			
Total No. of PAID	Lists transaction total and dollars for paid claims		

RA Field	Description
Each NPI/Owner Remittance Shall Contain the Following:	
Total No. of VOIDED	Lists transaction total and dollars for voided (reversed) claims
Total No. of DENIED	Lists transaction total and dollars for denied claims
Total of Withhold	Total recoupment transactions reducing the pharmacy provider's payment
Total of Payout	Total of transactions that increase the payment to the pharmacy provider
Grand Total	Lists transaction total and dollars for all claims – equals the check/EFT payment to the pharmacy provider

Table 3.3.3.1-1: Paper RA Field Descriptions

3.3.3.2 RA Samples

The Payee, Payee Number, Rx Number, Last Name, First Name, and Beneficiary ID Number are not included in the samples due to Protected Health Information (PHI)/Personally Identifiable Information (PII).

- The sample in *Figure 3.3.3.2-1* includes a negative balance recoupment (02N) in the amount of \$579.33, which is greater than the accumulated total of claim dollars to be paid, resulting in a zero-dollar (\$0.00) check amount.
- The sample in *Figure 3.3.3.2-2* includes a negative balance recoupment (02N) in the amount of \$6.96, which is less than the accumulated total of paid claim dollars, resulting in a check amount of \$132.31.
- Both RA examples also display the update made on September 12, 2023, populating the Amount Billed field with the GAD (NCPDP 430-DU) instead of the Usual and Customary (NCPDP 426-DQ) amount.

Payee: [REDACTED]
Payee No: [REDACTED]

REMITTANCE ADVICE
Medi-Cal RX(FI)
Administered By
PO Box 610
Rancho Cordova, CA 95741-0610



Run Date: 20-Feb-2025
Page: 2 of 3

Checkwrite Program: CAMEDICAL
Check / EFT Number: 7001482537
Check / EFT Date: 07-Mar-2025

RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
	18-Feb-25				57237003101	AMOXICILLIN	00	21	13.81	13.81	0.00	13.81	POS	N	
	17-Feb-25				00009057761	JANUMET	00	60	13.81	13.81	0.00	13.81	POS	N	
	17-Feb-25				50111078751	AZITHROMYCIN	00	6	13.64	13.64	0.00	13.64	POS	N	
	14-Feb-25				64380080806	IBUPROFEN	00	28	13.63	13.63	0.00	13.63	POS	N	
	17-Feb-25				64380080806	IBUPROFEN	00	28	13.63	13.63	0.00	13.63	POS	N	
	14-Feb-25				72578000701	METRONIDAZOLE	00	21	13.48	13.48	0.00	13.48	POS	N	
	17-Feb-25				68180098001	LISINOPRIL	00	30	13.50	13.25	0.00	13.25	POS	N	
	13-Feb-25				56151014260	TRUEPLUS LANCETS	00	100	14.22	12.80	0.00	12.80	POS	N	
	19-Feb-25				56151014260	TRUEPLUS LANCETS	00	100	14.22	12.80	0.00	12.80	POS	N	
	19-Feb-25				60505014200	GLIPIZIDE	00	360	20.07	0.00	0.00	0.00	POS	N	76
	19-Feb-25				60505014200	GLIPIZIDE	00	360	20.07	0.00	0.00	0.00	POS	N	76
	13-Feb-25				08317570050	GLUCOCARD EXPRESSION	00	100	23.04	0.00	0.00	0.00	POS	N	88
	14-Feb-25				65862094264	AZITHROMYCIN	00	4	14.57	0.00	0.00	0.00	POS	N	88
	17-Feb-25				00316018601	HYDROCORTISONE	00	28.4	16.55	0.00	0.00	0.00	POS	N	70
	19-Feb-25				60505014200	GLIPIZIDE	00	360	20.07	0.00	0.00	0.00	POS	N	76
	19-Feb-25				99073013001	FREESTYLE LANCETS	00	100	21.18	0.00	0.00	0.00	POS	N	76
	19-Feb-25				60505014200	GLIPIZIDE	00	360	20.07	0.00	0.00	0.00	POS	N	76
	19-Feb-25				99073070827	FREESTYLE LITE TEST STRIP	00	100	155.72	0.00	0.00	0.00	POS	N	76
	13-Feb-25				56151014260	TRUEPLUS LANCETS	00	100	-14.22	-12.80	0.00	-12.80	POS	N	
	17-Feb-25				50111078751	AZITHROMYCIN	00	6	-13.64	-13.64	0.00	-13.64	POS	N	
	19-Feb-25				50228043601	NAPROXEN	01	30	-14.11	-14.11	0.00	-14.11	POS	N	
	18-Feb-25				87701043462	VITAMIN D3	00	90	-15.61	-15.61	0.00	-15.61	POS	N	
	14-Feb-25				00555904958	CRYSELLE	00	84	-25.26	-25.26	0.00	-25.26	POS	N	
	05-Feb-25				331250205M01	POS - Negative Balance	00		0.00	0.00	0.00	-582.27	02N		
				Totals	56	Transactions			903.79	582.27	0.00	0.00			

Payee: [REDACTED]
Payee No: [REDACTED]

REMITTANCE ADVICE
Medi-Cal RX(FI)
Administered By
PO Box 610
Rancho Cordova, CA 95741-0610



Run Date: 20-Feb-2025
Page: 3 of 3

Checkwrite Program: CAMEDICAL
Check / EFT Number: 7001482537
Check / EFT Date: 07-Mar-2025

RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
		Error Code	Description												
		70	NDC not covered												
		76	Plan limitations exceeded												
		88	Dur reject error												
		Claim Type	Description												
		02N	Negative Balance												
		POS	POS Claim												
					Transactions		Amount Paid								
					Total No. of PAID		41 \$663.69								
					Total No. of VOIDED		5 -\$81.42								
					Total No. of DENIED		9 \$0.00								
					Total of Withhold		1 -\$582.27								
					Total of Payout		0 \$0.00								
					Grand Total		56 \$0.00								

Figure 3.3.3.2-1: Sample Paper RA – Recouped with a Zero Dollar Check Amount

Payee: [Redacted]
Payee No: [Redacted]

REMITTANCE ADVICE
Medi-Cal RX(FI)
Administered By
PO Box 610
Rancho Cordova, CA 95741-0610



Run Date: 20-Feb-2025
Page: 1 of 2

Checkwrite Program: CAMEDICAL
Check / EFT Number: 7001481465
Check / EFT Date: 07-Mar-2025

RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
	17-Feb-25				42571013252	CROMOLYN SODIUM	06	960	1,249.00	224.60	0.00	224.60	POS	N	
	17-Feb-25				00172640649	CROMOLYN SODIUM	00	120	412.89	152.70	0.00	152.70	POS	N	
	17-Feb-25				70954049210	LEVOCARNITINE	05	180	202.50	140.65	0.00	140.65	POS	N	
	17-Feb-25				00143965901	TESTOSTERONE CYPIONATE	00	4	91.40	62.14	0.00	62.14	POS	N	
	17-Feb-25				70700016201	PROGESTERONE	01	30	160.13	19.70	0.00	19.70	POS	N	
	18-Feb-25				00378827052	ALBUTEROL SULFATE	00	75	38.28	17.64	0.00	17.64	POS	N	
	17-Feb-25				68382013201	TAMSULOSIN HCL	00	90	384.22	16.73	0.00	16.73	POS	N	
	13-Feb-25				59651036205	IBUPROFEN	01	30	25.55	14.89	0.00	14.89	POS	N	
	13-Feb-25				68462039601	OMEPRAZOLE	01	30	134.00	14.12	0.00	14.12	POS	N	
	14-Feb-25				69452015120	VITAMIN D2	01	12	13.63	13.63	0.00	13.63	POS	N	
	19-Feb-25				68001049404	FAMOTIDINE	01	60	12.46	12.46	0.00	12.46	POS	N	
	14-Feb-25				00904723760	BANOPHEN	00	30	5.82	5.82	0.00	5.82	POS	N	
	17-Feb-25				08290309571	LUER-LOK SYRINGE-NEEDLE	00	4	5.75	0.88	0.00	0.88	POS	N	
	13-Feb-25				80681000500	CALCIUM	00	180	10.16	0.00	0.00	0.00	POS	N	88
	17-Feb-25				00172640649	CROMOLYN SODIUM	00	120	412.89	0.00	0.00	0.00	POS	N	88
	17-Feb-25				08290305195	REGULAR BEVEL NEEDLES	00	4	5.62	0.00	0.00	0.00	POS	N	85
	17-Feb-25				08290305195	REGULAR BEVEL NEEDLES	00	4	5.62	0.00	0.00	0.00	POS	N	85
	13-Feb-25				70700016201	PROGESTERONE	01	30	160.13	0.00	0.00	0.00	POS	N	88
	17-Feb-25				00143965901	TESTOSTERONE CYPIONATE	00	4	91.40	0.00	0.00	0.00	POS	N	80
	17-Feb-25				08290305195	REGULAR BEVEL NEEDLES	00	4	5.62	0.00	0.00	0.00	POS	N	85
	18-Feb-25				62991125001	PETROLATUM	00	70	97.31	0.00	0.00	0.00	POS	N	E1
	13-Feb-25				80681000500	CALCIUM	00	180	10.16	0.00	0.00	0.00	POS	N	88
	19-Feb-25				13811070610	METHYLPHENIDATE ER	00	30	285.24	0.00	0.00	0.00	POS	N	41
	17-Feb-25				68001049404	FAMOTIDINE	01	60	12.46	0.00	0.00	0.00	POS	N	88
	12-Feb-25					331250212M01 - POS - Negative Balance	00		0.00	0.00	0.00	-221.18	02N		
				Totals	25	Transactions			3,832.24	695.96	0.00	474.78			

Payee: [Redacted]
Payee No: [Redacted]

REMITTANCE ADVICE
Medi-Cal RX(FI)
Administered By
PO Box 610
Rancho Cordova, CA 95741-0610



Run Date: 20-Feb-2025
Page: 2 of 2

Checkwrite Program: CAMEDICAL
Check / EFT Number: 7001481465
Check / EFT Date: 07-Mar-2025

RX Number	Date Filled	Last Name	First Name	Beneficiary ID Number	National Drug Code	Drug Name	Refill	Qty	Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
				Error Code	Description										
				41	Submit bill to other processor or primary payor										
				80	Drug-diagnosis mismatch										
				85	Claim Not Processed										
				88	Dur reject error										
				E1	Alternate product type										
				Claim Type	Description										
				02N	Negative Balance										
				POS	POS Claim										
					Transactions		Amount Paid								
					Total No. of PAID		13 \$695.96								
					Total No. of VOIDED		0 \$0.00								
					Total No. of DENIED		11 \$0.00								
					Total of Withhold		1 -\$221.18								
					Total of Payout		0 \$0.00								
					Grand Total		25 \$474.78								

Figure 3.3.3.2-2: Sample Paper RA – Recoupment with Net Positive Check Amount

The RA is designed for line-by-line reconciliation of transactions. Reconciliation of the RA to pharmacy records will help determine which claims are paid, void/reversed, or denied (refer to the figures above for paper RA samples).

Paid:

Paid claims passed Medi-Cal Rx claim adjudication rules. They may be reimbursed as submitted or at reduced amounts according to Medi-Cal Rx reimbursement methodology.

Void/Reversed:

Void/Reversed claims are no longer eligible for payment. The claims may have been reversed by the pharmacy provider or by the Medi-Cal Rx vendor according to Medi-Cal Rx policy and specifications.

Denied:

Denied claims failed the Medi-Cal Rx claim adjudication rules and are unacceptable for payment due to one of the following common adjudication denial conditions, and a specific denial code is reported to explain the reason for the denial:

- Claim information cannot be validated, or
- The billed service is not a program benefit, or
- The claim failed the edit/audit process.

AR Transactions:

RAs may also reflect AR transactions when necessary either to recover funds from or pay funds to a provider. The Medi-Cal Rx vendor's AR system is used in financial transactions pertaining to the following:

- Recoupments to offset amounts owed to DHCS by the pharmacy provider,
- Withholds from payments to pharmacy providers according to DHCS-provided instructions, or
- Payments to pharmacy providers according to DHCS-provided instructions.

3.3.3.3 Dollar Sign Notation on RA

Effective December 15, 2023, the Medi-Cal Rx Paper RA and the corresponding PDF have been updated; the dollar sign (\$) symbols have been removed from the detail lines and now appear in the column headers for the following fields: Amount Billed, Amount Allowed, Amount Deducted, and Amount Paid. Refer to *Figure 3.3.3.3-1* and *Figure 3.3.3.3-2*. The RA PDFs available on the Medi-Cal Rx Finance Portal prior to December 15, 2023, remain unchanged.

Amount Billed	Amount Allowed	Amount Deducted	Amount Paid	Claim Type	PA Flag	Error Code
\$216.25	\$14.06	\$0.00	\$14.06	POS	N	
\$366.12	\$13.92	\$0.00	\$13.92	POS	N	
\$366.12	\$13.92	\$0.00	\$13.92	POS	N	
\$116.25	\$13.90	\$0.00	\$13.90	POS	N	

Figure 3.3.3.3-1: RA Before Update – Dollar Sign in Detail Lines

Amount Billed (\$)	Amount Allowed (\$)	Amount Deducted (\$)	Amount Paid (\$)	Claim Type	PA Flag	Error Code
4,293.69	3,792.17	0.00	3,792.17	POS	N	
3,112.99	2,886.35	0.00	2,886.35	POS	N	
1,945.99	1,804.62	0.00	1,804.62	POS	N	
1,945.99	1,804.11	0.00	1,804.11	POS	N	
1,883.69	1,638.88	0.00	1,638.88	POS	N	

Figure 3.3.3.3-2: RA After Update – Dollar Sign in Column Headers

3.4 Solving Technical Problems

In the event of POS system downtime (whether scheduled or unscheduled), providers will receive reject codes and supplemental messaging.

Refer to *Table 3.4-1* below for examples:

Reject Code	Message	Explanation
92	System Unavailable/ Host Unavailable	Processing host did not accept transaction or did not respond within time out period.
99	Host Processing Error	Do not retransmit claims.

Table 3.4-1: Reject Codes/Reject Messages

It is strongly encouraged that a pharmacy's software has the capability to submit backdated claims. Occasionally, a pharmacy may also receive messages that indicate its own network is having problems communicating with the Medi-Cal Rx vendor.

If this occurs, or if a pharmacy is experiencing technical difficulties connecting with the Medi-Cal Rx vendor's system, pharmacies should follow the steps outlined below:

1. Check the system status which can be found on the [Medi-Cal Rx Web Portal](#).
2. Check the terminal and communications equipment to ensure that electrical power and telephone services are operational.
3. Call the telephone number that the system is dialing and note the information heard (such as, fast busy, steady busy, recorded message).
4. Contact the software vendor if unable to access this information in the system.
5. If the pharmacy has an internal technical staff, forward the problem to that department.
6. If unable to resolve the problem after following the steps outlined above, directly contact the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

3.5 Automated Eligibility Verification System (AEVS)

The AEVS is an interactive voice response system that allows users the ability – through a touch-tone telephone – to access and clear SOC liability, and/or reserve a Medi-Service (a Medi-Service is **not** relevant to pharmacy providers).

Medi-Cal Rx pharmacy providers may use AEVS to look up SOC and do SOC spend downs.

Medi-Cal Rx pharmacy providers should use the POS system or the Member Eligibility Lookup Tool accessible via the [Medi-Cal Rx Secured Provider Portal](#) to verify member eligibility.

AEVS Telephone Number: 1-800-456-AEVS (2387)

While no enrollment is necessary to participate and utilize AEVS, Providers must use a valid Provider Identification Number (PIN), which is issued when providers enroll with Medi-Cal. In the instance when a provider does not remember their PIN, the TSC technical help desk agents are authorized to release the existing PIN once caller validation protocols have been completed. Providers may call the TSC at 1-800-541-5555.

Note: The TSC is *different* from the Medi-Cal Rx Customer Service Center (CSC).

As PIN release is governed by discrete caller validation protocols, there are circumstances in which the TSC technical help desk agent may only be authorized to re-issue the PIN letter with the existing PIN. If this is authorized, the PIN letter will be sent to the provider’s pay-to address on file.

For more detailed information related to AEVS refer to the applicable links in the [DHCS Provider Manual \(Part 1 – Medi-Cal Program and Eligibility\)](#).

Refer to *Table 3.5-1* for additional contact information.

For Questions About	Call
Operations of AEVS	Help Desk: 1-800-427-1295
For AEVS, AEVS PIN related inquiries and any non-Medi-Cal Rx related inquiries	Telephone Support Center (TSC): 1-800-541-5555

Table 3.5-1: Additional Number Directory

3.6 Medi-Cal Rx Web Portal

The Medi-Cal Rx Web Portal can be accessed at <https://medi-calrx.dhcs.ca.gov/home/>. This dedicated website offers content available on a public platform that is accessible by all. Additionally, secured portals will be available to members, prescribers, pharmacies, billing agents, and health plan partners to ensure that they can access appropriate tools for services that require access to Protected Health Information (PHI).

The following tools are available to pharmacies, prescribers, and health plan partners:

- [Frequently Asked Questions \(FAQs\)](#) – The FAQ page can be accessed at the top of the Medi-Cal Rx home page. The FAQs provide additional guidance and clarification regarding the transition of Medi-Cal’s pharmacy benefit (Medi-Cal Rx). More specific information can be found by using the list of categories on the left side of the FAQ page.

- [Medi-Cal Rx Subscription Service \(MCRxSS\)](#) – The MCRxSS is a free service that keeps pharmacies and prescribers up to date on the latest Medi-Cal Rx news. Subscribers will receive subject-specific emails for urgent announcements and other updates shortly after the updates are posted to the [Medi-Cal Rx Web Portal](#).
 - To enroll for MCRxSS, click **Subscribe Today** under the Medi-Cal Rx Subscription Service (MCRxSS) in the center of the Medi-Cal Rx home page. A new window will open and require an email address, ZIP code, and subscriber type, and provide options to choose subjects of interest.
 - **Note:** Enrolling in the MCRxSS is optional.
- [Education and Outreach](#) – Education and Outreach information can be accessed by selecting **Education & Outreach** at the top of the Medi-Cal Rx Web Portal. Topics on the Education & Outreach page include Medi-Cal Rx Background, Overview, Pharmacy Transition Policy, Communication & Training Schedule, and Training Materials and Resources.
- [Find a Pharmacy](#) – Users can enter their location and view pharmacies in their area that participate in Medi-Cal. The search results can be easily sorted and filtered to find a pharmacy that specifically fits the user preferences.
- [Drug Lookup](#) – This tool is interactive and offers real-time drug lookup. The Drug Lookup feature can be used by anyone to easily search by drug name or NDC and provides coverage information along with any PA requirements, quantity limitations, and generic/brand indications.
- [Medi-Cal Rx Contract Drugs List](#) (CDL) – A document containing the complete CDL, which is categorized by drug class and contains dose and strength information, along with coverage restrictions and is searchable.
 - **Note:** The CDL is accessible on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Enteral Nutrition Products](#) – This list provides all Medi-Cal Rx contracted enteral nutrition products (for more information on enteral nutrition, refer to [Section 12.0 – Enteral Nutrition Products](#)).
 - **Note:** The *List of Contracted Enteral Nutrition Products* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Diabetic Testing Supplies](#) – This list provides all Medi-Cal Rx contracted diabetic testing supplies (for more information on Diabetic Supplies, refer to [Section 13.0 – Medical Supplies](#) and [Section 13.1 – Diabetic Testing Supplies – Test Strips, Lancets, Self-Monitoring Blood Glucose Systems \(Glucometers\), Control Solutions, and Lancing Devices](#)).
 - **Note:** The *List of Contracted Diabetic Testing Supplies* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.

- [List of Contracted Self-Monitoring Blood Glucose Systems \(Glucometers\), Control Solutions, and Lancing Devices](#) – This list provides all Medi-Cal Rx contracted Diabetic Blood Glucose testing monitors (Glucometers), compatible contracted control solutions, and contracted lancing devices. For more information on these products, refer to [Section 13.0 – Medical Supplies](#) and [Section 13.2 – Diabetic Supplies – Disposable Insulin Delivery Devices](#).
 - **Note:** The *List of Contracted Self-Monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Disposable Insulin Delivery Devices](#) – This list provides all Medi-Cal Rx contracted disposable insulin delivery devices (DIDDs) (for more information, refer to [Section 13.0 – Medical Supplies](#) and [Section 13.3 – Diabetic Supplies – CGM Systems](#)).
 - **Note:** The *List of Contracted Disposable Insulin Delivery Devices* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Continuous Glucose Monitoring \(CGM\) Systems](#) – This list provides all Medi-Cal Rx contracted Continuous Glucose Monitoring (CGM) Systems (for more information, refer to [Section 13.0 – Medical Supplies](#) and [Section 13.4 – Personal Home Blood Pressure Monitors and Cuffs](#)).
 - **Note:** The *List of Contracted Continuous Glucose Monitoring (CGM) Systems* can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Pen Needles](#) – This list provides all Medi-Cal Rx contracted Pen Needles (for more information on Diabetic Supplies, refer to [Section 13.0 – Medical Supplies](#)).
 - **Note:** The *List of Contracted Pen Needles* is accessible on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [List of Contracted Blood Pressure Monitors and Cuffs](#) – This list provides all Medi-Cal Rx contracted blood pressure monitoring devices and blood pressure cuffs (for more information, refer to [Section 13.0 – Medical Supplies](#)).
 - **Note:** The *List of Contracted Blood Pressure Monitors and Cuffs* is accessible on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.
- [Drug Use Review \(DUR\)](#) – This page contains comprehensive information regarding the DUR program.
- [System Status Information](#) – This page ensures that all system issues are reported in real time for planned and unplanned occurrences.
- [Forms & Information](#) – Users can easily access forms and information related to Medi-Cal Rx (paper claim forms, PA forms, appeal forms, etc.).
- Glossary – Provides easy explanations for many Medi-Cal Rx pharmacy and health-related terms.

- Medi-Cal Rx Complaints and Grievances Process – Provides helpful resources and tools relative to Medi-Cal Rx's Complaints and Grievances Processes and Protocols, inclusive of background information, definitions, CSC contact information, and applicable forms.
- Mass Adjustments – Provides users with the status of completed Mass Adjustments.
- [Medi-Cal Rx Billing Tips](#) – Provides a high-level overview of billing requirements that have changed with the transition to FFS. The document is available to download and/or print and used as a job aid to pharmacies and prescribers.

3.6.1 Medi-Cal Rx Provider Portal

Pharmacies and prescribers can access the unsecured (no login required) and secured Medi-Cal Rx Provider Portals (registration and login required) from the [Medi-Cal Rx Provider Portal](#).

3.6.1.1 Unsecured Provider Portal

Utilizing the [Medi-Cal Rx Provider Portal](#) gives users access to several features and functions without requiring credentials to log in.

On the left side of the screen, several options are available. Refer to *Figure 3.6.1.1.-1*.

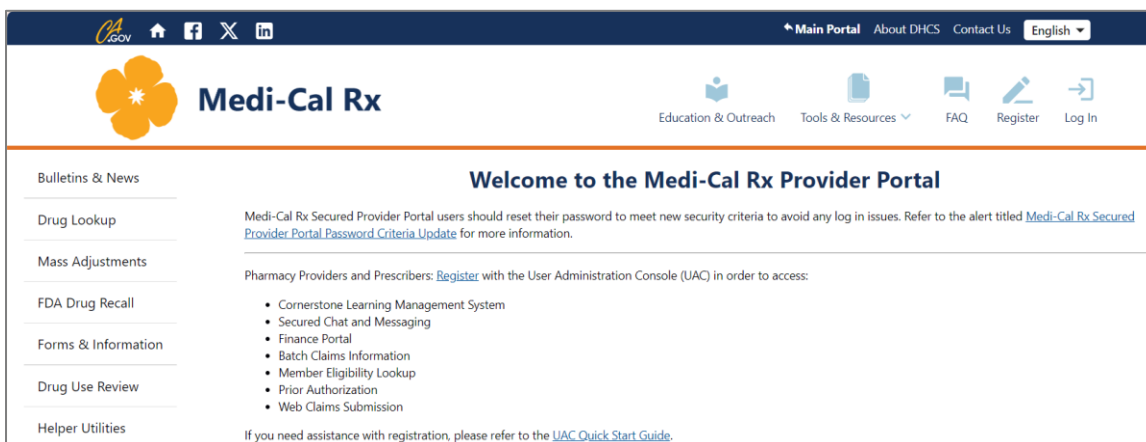


Figure 3.6.1.1-1: Unsecured Provider Portal

Each of the options are links to a separate area of the Medi-Cal Rx Provider Portal.

- [Bulletins and News](#) will take the user to a list of bulletins containing articles and announcements of provider manual updates, general billing and policy changes related to Medi-Cal Rx. This link will also provide news regarding urgent and late breaking information that is updated throughout the month and training schedules with links to registration.
- [Drug Lookup](#) is an interactive tool that allow users real-time drug lookup. The Drug Lookup feature can be used to easily search by drug name or NDC and provides coverage information along with any PA request requirements, quantity limitations, and generic/brand indications.

- [Forms & Information](#) includes, but is not limited to, the following:
 - Reference Materials
 - Billing Tips and Payer Sheets
 - Covered Products Lists
 - Contract Drugs Lists (CDL) – Searchable documents categorized by drug class and contains dose and strength information along with coverage/coverage restrictions.
 - Other Lists of Covered Products
 - Contracted Enteral Nutrition Products
 - Contracted Diabetic Testing Supplies
 - Contracted Self-Monitoring Blood Glucose Systems (Glucometers) Control Solutions, and Lancing Devices
 - Contracted DIDDs Systems
 - Contracted Pen Needles
 - Covered Sterile Syringes with Needles (non-insulin)
 - Family PACT Pharmacy Formulary
 - Pharmacy Reimbursable Physician Administered Drugs (PADs)
 - *Medi-Cal Rx Electronic Funds Transfer (EFT) Authorization Agreement Form* (DHCS 6551) for EFT application/authorization
 - *Medi-Cal Rx Electronic Remittance Advice (ERA) Authorization Agreement Form* (DHCS 6550) for ERA application/authorization
 - *Medi-Cal Rx Provider Manual*
 - Downloadable Forms (Paper Claim Forms, PA Request Forms, Provider Claim Appeal(s) Forms, etc.)
 - Provider Welcome Packet
- [Drug Use Review \(DUR\)](#) provides comprehensive information regarding the DUR program.
- [Helper Utilities](#) is an area where the tools needed to support a Medi-Cal Rx Web Portal user can be found. It is important to note that the [Medi-Cal Rx Web Portal](#) will not operate correctly using the Internet Explorer (IE) browser. The Helper Utilities page provides links to alternate browsers that support use of the portal.

3.6.1.2 Secured Provider Portal

Pharmacy providers and prescribers wishing to access the [Medi-Cal Rx Secured Provider Portal](#) can assign a designated staff member to complete registration via the User Administration Console (UAC) application (the UAC is a registration tool that controls and manages the user's access to the secured portal). Refer to *Figure 3.6.1.2-1*. Once this person has successfully registered, he or she can then set up the remaining staff members and grant them access to the tool.

In order to register via the UAC, providers can click the **Register** link on the [Medi-Cal Rx Provider Portal](#). That link will provide a “UAC Quick Start Guide,” which gives step-by-step instructions on how to register for the secured portal and associated applications.

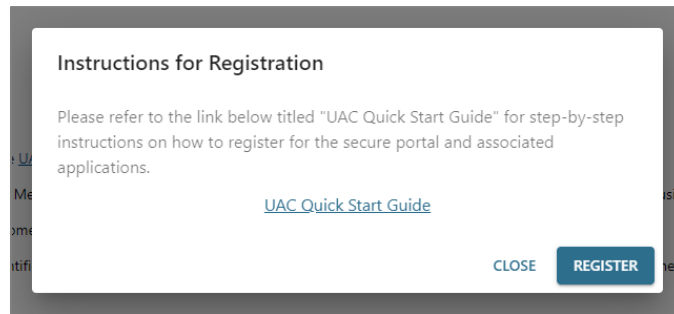


Figure 3.6.1.2-1: Secured Provider Portal

3.6.1.2.1 Web Claims Submission/Direct Data Entry

The Web Claims Submission (WCS)/Direct Data Entry tool allows pharmacy providers to securely (once registered and logged in):

- Submit claims (including reversals and resubmissions).
 - The *NCPDP Payer Specification Sheet* (refer to [Appendix A – NCPDP Payer Specification Sheet](#)) will provide users with a list of required and situational fields and the valid values for those fields when submitting a claim using WCS.
- Search for claims by cardholder ID and fill date.
 - **Note:** Providers using the WCS tool to search for claims will only be able to search and view claims that were submitted using their NPI.

3.6.1.2.2 Prior Authorization Requests

The prior authorization (PA) request tool will allow pharmacies and prescribers to initiate a PA, inquire on a PA status, cancel a PA, add information to an existing PA, and upload attachment to an existing PA. Refer to *Figure 3.6.1.2.2-1*.

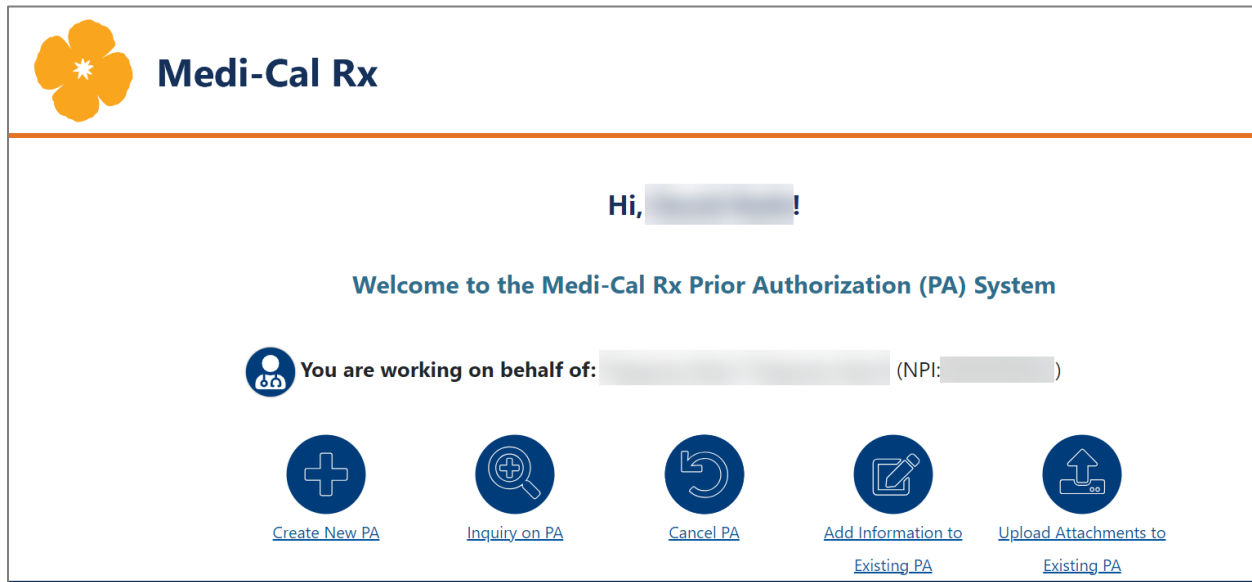
The screenshot shows the Medi-Cal Rx Prior Authorization (PA) System interface. At the top left is the Medi-Cal Rx logo, which consists of an orange flower icon and the text "Medi-Cal Rx". Below the logo, there is a greeting "Hi, [redacted]!". Underneath the greeting is the text "Welcome to the Medi-Cal Rx Prior Authorization (PA) System". Below this, there is a section titled "You are working on behalf of:" followed by a redacted name and "(NPI: [redacted])". At the bottom of the interface, there are five circular icons with corresponding text links: "Create New PA", "Inquiry on PA", "Cancel PA", "Add Information to Existing PA", and "Upload Attachments to Existing PA".

Figure 3.6.1.2.2-1: Prior Authorization Screen

Note: A link to CoverMyMeds® (a tool allowing a true electronic PA [ePA]) can be submitted in real-time by *prescribers*, with most decisions happening in real-time (refer to [Section 14.4 – CoverMyMeds for ePA Requests](#)). The Medi-Cal Rx vendor’s PA fax form will also be available on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information**.

3.6.1.2.3 Cornerstone Learning Management System

The **Cornerstone Learning Management System** (LMS) is a training and learning platform that ensures providers have access to appropriate, secure training so that the tools and resources offered can be fully utilized.

The LMS includes:

- Presentations about the Medi-Cal Rx transition and new Medi-Cal Rx resources, including contact information, access points for applications and services, and differences in processes and procedures from a provider perspective.
- Computer-Based Trainings for applications or processes/procedures that providers will use such as Member Eligibility, WCS, and PA requests.
- Application user guides and job aids.
- Informational materials including coverage policy and billing guidance.
- Provider surveys that allow providers access to a survey link they can use to provide feedback on their experience.

3.6.1.2.4 Additional Resources

The [Medi-Cal Rx Secured Provider Portal](#) also provides access to the following:

Tools & Resources

- Member Eligibility Lookup Tool – Accessible after successful login. This tool allows users to verify the eligibility of a member. Refer to *Figure 3.6.1.2.4-1*.

The screenshot shows the 'Member Eligibility Lookup' tool interface. At the top, there is a Medi-Cal Rx logo and navigation links: Message Center, Account Settings, Tools & Resources (with a dropdown arrow), and Log Out. The main heading is 'Member Eligibility Lookup', followed by a subtitle: 'Member eligibility data for Medi-Cal Rx Pharmacy Prior Authorizations and Claims only.' and a note '* Indicates required field'. The form contains five input fields: 'Last Name: *' with a placeholder 'Enter last name here'; 'Birth Date: *' with a placeholder 'Enter as mm/dd/yyyy' and a calendar icon; 'Service Date: *' with a placeholder '06/25/2024' and a calendar icon; 'Search By: *' with a dropdown menu currently showing 'Member ID Number'; and 'Enter Member ID or Client Index Number here: *' with a placeholder 'Enter Member ID or Client Index Number here'. Below these fields is a note: 'Please enter the Member ID Number or Client Index Number only.' At the bottom are two buttons: 'CLEAR' and 'SEARCH'.

Figure 3.6.1.2.4-1: Member Eligibility Lookup Tool

- **Note:** This tool does not show the member's real-time eligibility information but is current as of the prior day. Providers may view real-time eligibility utilizing the Prior Authorization link from the Tools & Resources drop-down list.
- Password Management – Users will be able to manage passwords from one centralized location.

Contact Us

- Secured Message Center – Accessible after successful login. Pharmacies and prescribers can compose and reply to message.
 - **Note:** Users cannot reply to a message for which a response has not yet been received from a CSR. When a response has been sent to the provider an email notification will be sent to him/her.
- Secured Chat – Accessible after successful login. Provides the ability for users to connect in real-time. Refer to *Figure 3.6.1.2.4-2*.

- **Note:** A chat window will open, users can start typing questions and a “bot” will answer specific predetermined questions. If further assistance is needed, the user will be connected to a CSR.

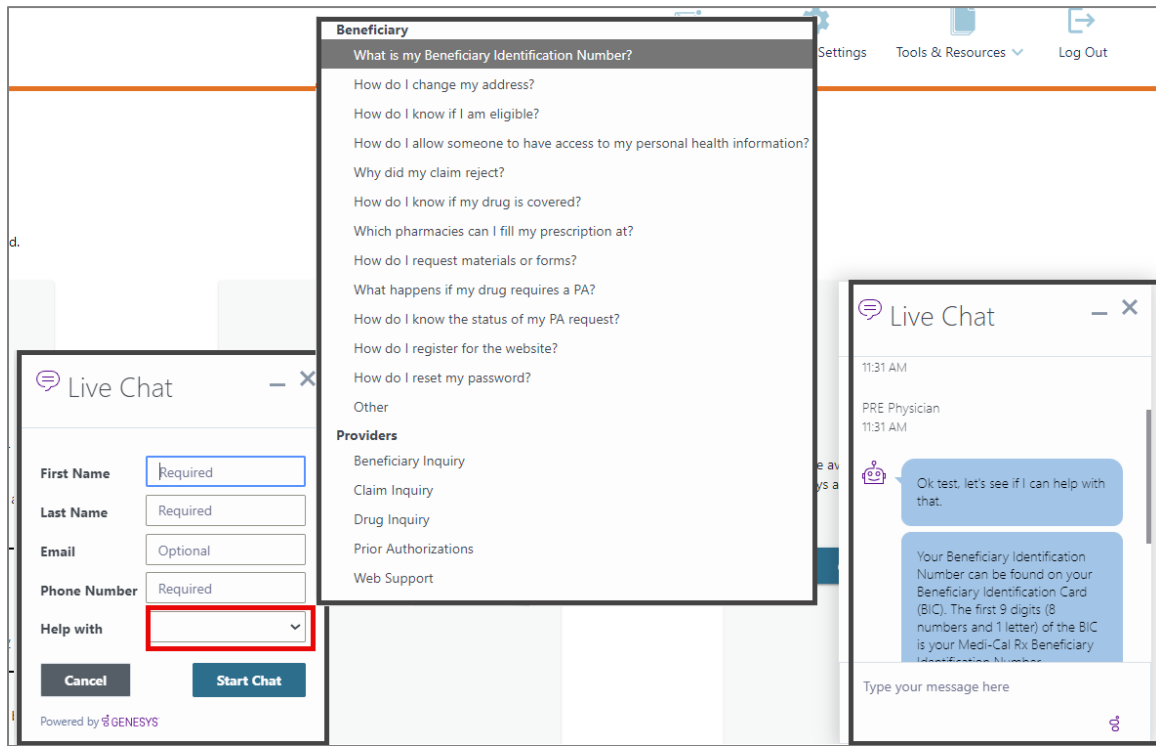


Figure 3.6.1.2.4-2: Secured Chat

4.0 Claims

4.1 Claim Format

While the Medi-Cal Rx vendor strongly recommends claims submission by point of sale (POS), for certain billings outside of the norm, batch submission, paper claims, and web claims may be utilized or required. The following HIPAA formats in *Table 4.1-1* are accepted. Each is explained in subsequent sections.

Accepted Claim Formats		
Description	Format	Comments
POS Compound and non-compound pharmacy claims may be submitted through the POS network.	NCPDP D.0	Online POS submission is preferred.

Accepted Claim Formats		
Description	Format	Comments
Provider Compound and non-compound pharmacy claims may be submitted on the Paper Claim forms mentioned in the next column	<i>Universal Claim Form (UFC)</i> (refer to Section 19.1 – Universal Claim Form, Version D.0), or <i>California Pharmacy Claim Form (30-1)</i> (for non-compound claims) (refer to Section 19.2.1 – California Specific Pharmacy Claim Form (30-1)) or <i>California Compound Pharmacy Claim Form (30-4)</i> (for compound) (refer to Section 19.2.2 – California Specific Compound Pharmacy Claim Form (30-4))	UFC is used when billing for drugs, covered medical supplies, or compound claims. California Specific Pharmacy Claim Form (30-1) is used when billing for drug-covered medical supply claims and for crossover claims. California Specific Compound Pharmacy Claim Form (30-4) is used when billing for multi-ingredient compound pharmacy claims, single-ingredient sterile transfer claims, and for crossover claims.
Beneficiary Submitted Paper	<i>Beneficiary Reimbursement Claim Form</i> (refer to Section 19.6 – Member Reimbursement Claims)	Also referred to as a “Conlan” claim.
Claim Inquiry Form (CIF)	CIF (refer to Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form (CIF) (DHCS 6570))	CIF are used <i>after</i> submitting a claim to request one of the following: <ul style="list-style-type: none"> • An Adjustment • Reconsideration • Tracer
WCS (Direct Data Entry)	NCPDP D.0	
Batch File Transfer Protocol (FTP)	NCPDP Batch 1.2	SFTP is the communication method for batch files/media.

Table 4.1-1: Accepted Claim Formats

4.2 NCPDP Version D.0

The Medi-Cal Rx vendor uses a claim(s) processing system that verifies at a minimum the following categories:

- NCPDP claim submission standards
- Member eligibility
- Drug Coverage
- Dispensing limits
- Pricing
- Payment Information
- ProDUR

Note: The Medi-Cal Rx vendor's claim(s) processing system provides real-time claims messaging and reject codes when a claim is submitted via POS or Web-Claim Submission/Direct-Data Entry. For example, drug products that have dispensing limits will deny with Reject Code 76 – Plan Limitations Exceeded, if the product was submitted for greater than the allowed limit.

The POS system is used in conjunction with a pharmacy's in-house operating system. While there are a variety of different pharmacy operating systems, the information contained in this manual specifies only the response messages related to the interactions with the Medi-Cal Rx vendor's online system and not the technical operation of a pharmacy's in-house-specific system. Pharmacies should check with their software vendors to ensure their system is able to process the payer specifications listed in [Appendix A – NCPDP Payer Specification Sheet](#) of this manual.

4.2.1 Supported Transaction Types

The Medi-Cal Rx vendor has implemented the following NCPDP Version D.0 transaction types. A pharmacy's ability to use these transaction types will depend on its software. At a *minimum*, pharmacies should have the capability to submit original claims (B1), reversals (B2), rebills (B3), and eligibility verification transactions (E1). Other transactions supported by Medi-Cal Rx can be found in the [Medi-Cal Rx NCPDP Payer Specification Sheet](#).

- Full Claims Adjudication (Code B1) – This transaction captures and processes the claim and returns the dollar amount allowed under the program's reimbursement formula. The B1 transaction will be the prevalent transaction used by pharmacies.
- Claims Reversal (Code B2) – This transaction is used by a pharmacy to cancel a claim that was previously adjudicated. The pharmacy must locate the paid claim which they would like to reverse and then select the reversal option. Pursuant to CCR, Title 22, Section 51172, if a prescription has not been received by the member or the member's representative within 15 days of the fill date, the pharmacy must reverse the claim and refund the payment to DHCS.

- **Note:** Claims that have not successfully paid (adjudicated) cannot be reversed. Providers may contact the CSC at 1-800-977-2273 if an override is required for a reversal that has not successfully processed.
- Claims Rebill (Code B3) – This transaction is used by the pharmacy to adjust and resubmit a claim that has received a PAID status. A “claim rebill” voids the original claim and resubmits the claim within a single transaction. The B3 claim is identical in format to the B1 claim with the only difference being that the transaction code (Field # 103) is equal to B3.
- Eligibility Inquiry (Code E1) – This transaction is used by the pharmacy to provide the status of a member’s Medicare health plan covering the individual, along with details regarding primary and supplemental coverage if applicable.

Note: The following fields must match the original paid claim for a successful transmission of B2 (Reversal) or B3 (Rebill):

- Service Provider Identification (ID) – NCPDP Provider Number
- Prescription Number
- Date of Service (Date Filled)

4.2.2 Nonsupported Transaction Types

The Medi-Cal Rx vendor’s POS system will **not** accept the following NCPDP Version D.0 transaction types:

- N1 = Information Reporting
- N2 = Information Reporting Reversal
- N3 = Information Rebill
- C1 = Controlled Substance Reporting
- C2 = Controlled Substance Reporting Reversal
- C3 = Controlled Substance Reporting Rebill

Note: Providers that report 340B claims on N-Type transactions are not and will not be considered compliant with DHCS policy.

4.2.3 Required Data Elements

When a pharmacy is setting-up their POS system to allow access to required fields and to accept adjudication for Medi-Cal Rx claims, the pharmacy’s software vendor needs the Medi-Cal Rx vendor’s payer specifications (refer to [Appendix A – NCPDP Payer Specification Sheet](#)).

The Medi-Cal Rx vendor’s claims processing system has program specific field requirements (such as, mandatory, required, and required when).

Medi-Cal Rx claims will not be processed without all the required (or mandatory) data elements. Required (or mandatory) fields may or may not be used in the adjudication process. Also, fields not required at this time may be required at a future date.

Payer Specifications and Program Set-up Information

A list of supported transaction types and their field requirements, as well as BIN, PCN, Group#, etc., is available and can be found in [Appendix A – NCPDP Payer Specification Sheet](#).

4.3 NCPDP Batch File Submission

Pharmacy providers who are interested in submitting batch files to Medi-Cal Rx for pharmacy claims, pharmacy PAs, and/or member eligibility verification must ensure the transactions adhere to the NCPDP Versions D.0 and 1.2 Standards. Refer to the [Medi-Cal Rx NCPDP Payer Specification Sheet](#) for additional information on the NCPDP transactions and standards.

To initiate the Medi-Cal Rx batch file submission process, send an email request to MediCalSystemsGroup@primetherapeutics.com with the following information:

- As the subject line of the email, include text of "Medi-Cal Rx Batch File Setup Request for [pharmacy name]" to ensure the email is appropriately directed.
- In the body of the email, include:
 - Pharmacy Provider Business Name(s)
 - Pharmacy Provider Service/Business Address(es)
 - Pharmacy NPI(s)
 - Contact Name
 - Contact Phone Number
 - Contact Email Address

Once the request email is received, a Medi-Cal Rx project manager will be in contact to discuss the next steps.

4.4 Paper Claim(s)

All pharmacy and member paper claims must be submitted to the Medi-Cal Rx vendor via one of the following forms:

- UCF
- *California Specific Pharmacy Claim Form (30-1)* (for non-compound claims)
- *California Specific Compound Pharmacy Claim Form (30-4)* (for compound claims)

[Appendix B – Directory](#) at the end of this manual specifies:

- The source for obtaining UCFs, *California Pharmacy Claim Form (30-1)* and *California Compound Pharmacy Claim Form (30-4)*.
- The mailing address pharmacies must use when sending completed paper claims/billings.

Completion instructions for the UCF, *California Specific Pharmacy Claim Form (30-1)*, and *California Specific Compound Pharmacy Claim Form (30-4)* are listed in the following sections:

- [Section 19.1.1 – Completion Instructions for the UCF](#)
- [Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#)

- [Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#)

Examples of claims for which a UCF, *California Specific Pharmacy Claim Form* (30-1) or *California Specific Compound Claim Form* (30-4) may be submitted include, but are not limited to, the following:

- Prescriptions Exceeding the Timely Filing Limit:
 - Paper claims are allowed when the timely filing limit is exceeded.
 - The pharmacy is responsible for obtaining an authorization override prior to submitting paper claims.
 - Paper claims requiring authorization overrides that are submitted without the pharmacy first obtaining the authorization override will be denied with the applicable reject code and messaging. The denial will be visible via the [Medi-Cal Rx Provider Portal](#), the POS claim system, or on the RA once the paper claim has been processed.
- Non-Compound Claims (UCF or *California Specific Pharmacy Claim Form* (30-1))
- Multi-Ingredient Compound Claims (UCF or *California Specific Compound Pharmacy Claim Form* (30-4))
- Claims submitted for drug NDCs in which a price is not available for the “inner” NDC but is available for the “outer” NDC (or vice versa). For additional information, refer to [Section 4.4.1 – Missing Price](#).

Note: Claims made by a member can be submitted using the *Beneficiary Reimbursement Claim Form* (sometimes referred to as a “*Conlan Claim Form*”). Additional information regarding member claims can be found in [Section 19.6 – Member Reimbursement Claims](#).

4.4.1 Missing Price

Reimbursement for any outpatient drug (including over-the-counter [OTC] drugs, physician administered drugs [PADs], and vaccines) covered under Medi-Cal Rx is based upon various price types that DHCS deems appropriate as identified in [Section 4.6.1 – Legend and Non-Legend Drugs](#). If a drug NDC does not have one of the Medi-Cal Rx recognized price types for reimbursement, claims submitted to Medi-Cal Rx will deny with Reject Code 85 – Claim Not Processed with the supplemental message “No price exists for the NDC submitted.”

Note: Medi-Cal Rx utilizes First DataBank (FDB) as its primary source for drug, NDC, and price information. Manufacturers are responsible for providing FDB with all of the information regarding their products.

“Inner” and “Outer” NDCs for Outpatient Drugs

“Inner” and “outer” NDCs for outpatient drugs are a Medi-Cal Rx benefit if the manufacturer reports the price to FDB and the Medi-Cal Rx approved reimbursement methodology can be applied to the claim when processed through the POS claim system. If the manufacturer does not report the NDC price, the claim cannot be processed and the claim will deny with Reject Code 85. This occurs when the “outer” NDC has a price, but the “inner” NDC does not.

Pharmacy providers who receive a denied claim for Reject Code 85 when submitting a claim using the “inner” NDC are recommended to resubmit the claim using the “outer” NDC to align with available manufacturer prices. This ensures that the claim can reimburse accurately and in a timely manner.

If the “outer” NDC cannot be used for claim submission, pharmacy providers may submit a paper claim for the drug via the UCF or *California Specific Pharmacy Claim Form* (30-1). For compound claims, the *California Specific Compound Pharmacy Claim Form* (30-4) may be used. Pharmacy providers will be required to include the 11-digit “inner” NDC that was used to dispense the prescription along with the “outer” NDC and corresponding claim line number in the remarks area of the claim form. Reimbursement will be calculated using the NDC units of measure (for example, milliliters, grams, etc.) along with the “outer” NDC price. If the paper claim is submitted for the “inner” NDC but does not include the “outer” NDC as a remark on the claim form, the request will be denied.

Although less common, other situations that may occur include the following:

- The “inner” NDC has a price, but the “outer” NDC does not. In these situations, it is recommended to continue processing the claim using the “inner” NDC.
- Both the “outer” and “inner” NDCs do not have a price. In these situations, it is recommended to consider dispensing the drug using an alternate payable NDC from a different manufacturer.

Notes:

- Submission of a paper claim in situations of Reject Code 85 does **not** guarantee reimbursement. The claim will continue to be subjected to Medi-Cal Rx policy and claim processing requirements and may deny with reject codes as a result of those requirements.
- The above does not apply to medical supplies. If a claim submitted for a medical supply denies for Reject Code 85, the pharmacy provider should submit the claim to the member’s medical benefit for coverage considerations.

4.5 Web Claims Submission/Direct-Data Entry

The WCS/Direct Data Entry tool allows pharmacy providers to securely (once registered via UAC and logged in) submit claims and PA requests and also search for claims by Cardholder ID and fill date. For more information on WCS/direct-data entry, refer to [Section 3.6.1.2.1 – Web Claims Submission/Direct Data Entry](#). For information on PA requests and submission methods, refer to [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#).

4.6 Reimbursement

The following sub-sections contain information regarding how reimbursement is calculated for legend, non-legend drugs, select medical supplies, and enteral nutrition products.

4.6.1 Legend and Non-Legend Drugs

Reimbursement for any outpatient drug (including OTC drugs, PADs, and vaccines) covered under Medi-Cal Rx is the lowest of either of the following:

1. The drug's ingredient cost, plus a professional dispensing fee.
 - a. Where the drug's ingredient cost is equal to the lowest of the following:
 - i. National Average Drug Acquisition Cost (NADAC), or when no NADAC is available, the Wholesale Acquisition Cost (WAC).
 - ii. Maximum Allowable Ingredient Cost (MAIC).
 - iii. Federal Upper Limit (FUL).
2. The pharmacy's usual and customary charge.

Note: Additional product cost due to special packaging will not be reimbursed (for example, unit of use, modified unit dose, or unit dose).

4.6.2 Professional Dispensing Fee

Unless noted otherwise below, DHCS utilizes a two-tiered professional dispensing fee based on a pharmacy's total (both Medicaid and non-Medicaid) annual claim volume as follows:

- Less than 90,000 claims per year = \$13.20
- 90,000 or more claims per year = \$10.05

Note: No fee or markup is calculated when the Total Ingredient/Product Cost is equal to \$0.00. This applies to the two-tier professional fee, sterilization, and compounding fees.

4.6.2.1 Pharmacy Provider Self-Attestation

Pursuant to W&I Code, Section 14105.45, the two-tiered professional dispensing fee is based on a pharmacy provider's total (Medi-Cal Rx and non-Medi-Cal Rx) annual pharmacy claim volume (\$13.20 if fewer than 90,000 claims per year; \$10.05 if 90,000 or more). Reporting the claim volume is a self-attestation process, which must be submitted electronically and must be repeated annually.

Note: DHCS policy is that a claim is equivalent to a dispensed prescription; therefore, the attestation is for the total dispensed prescription volume.

Only Medi-Cal Rx providers dispensing less than 90,000 total prescriptions per calendar year are eligible to receive the higher of the two professional dispensing fees, and they must complete the attestation annually in order to receive it. Medi-Cal Rx providers with more than 90,000 total prescriptions are not required to participate in the annual attestation process. Providers that do *not* submit a timely attestation will be automatically assigned the lower of the two professional dispensing fees.

Self-attestations for each calendar year will begin in March after the close of the calendar year. The attestation period lasts approximately four weeks.

The attestation for each calendar year reporting period will determine the professional dispensing fee component of the pharmacy claim reimbursement for claims with dates of service (DOS) within the state's following fiscal year. As an example, the 2021 calendar year volume attestation will determine the professional dispensing fee for claims within the State's 2022-2023 fiscal year (dates of service *on or after* July 1, 2022, through June 30, 2023).

4.6.2.2 Professional Dispensing Fee Limitations, Frequency of Billing

- Pursuant to CCR, Title 22, Section 51513(b)(3), full payment (drug ingredient cost plus a professional dispensing fee component) to a pharmacy is limited, based on policy for specific products, to a maximum of 3 claims for the same drug and strength dispensed to the same member within any 75-day period. The 4th claim from any provider, and any subsequent claims for the same drug and strength dispensed to the same member within any 75-day period will not be paid a dispensing fee, claims will be paid at the ingredient cost only.
- The exceptions to the frequency of billing rule as mentioned above are:
 - If it is the initial prescription.
 - When authorization is obtained for more frequent billing.
 - When drugs are dispensed in a quantity of 180 or more tablets or capsules.

Examples of Professional Dispensing Fee Control Exceptions:

- Oral Contraceptives require a minimum dispensing quantity of 3 cycles. Liquid Potassium products and Theophylline products require a minimum dispensing quantity of 480cc. If claims for those products are submitted for less than the stated minimum dispensing quantity, as a 30-day supply, the pharmacy will only get a dispensing fee for the first fill. On subsequent fills, only an ingredient cost will be paid and no dispensing fee.
 - The exceptions for the minimum quantity restrictions mentioned above are:
 - If it is the initial prescription.
 - When a PA is obtained for a smaller quantity.

Refer to the CDLs (found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**) for drugs/products that have a frequency of billing requirement. These products will be marked with a symbol (+).

4.6.3 Drug Price Types

4.6.3.1 National Average Drug Acquisition Cost (NADAC)

When available, the NADAC is used in the formula for determining drug ingredient cost reimbursement for covered outpatient drugs. The NADAC is a national drug-pricing benchmark determined by a federal survey, representing the national average invoice price for drug products based on invoices from wholesalers and manufacturers submitted by retail community pharmacies.

Note: It is the responsibility of providers to monitor the published NADAC pricing on the Centers for Medicare & Medicaid Services (CMS) Pharmacy pricing website. Providers may request a NADAC rate review by completing the NADAC *Request for Medicaid Reimbursement Review* form found at www.medicaid.gov.

4.6.3.2 MAIC Reimbursement Program

The DHCS has contracted with the Medi-Cal Rx vendor, who contracted with Mercer Government Human Services Consulting (Mercer), part of Mercer Health and Benefits LLC, to establish and maintain an MAIC program for generic pharmaceutical drugs.

The objective of the MAIC program is to establish upper limit generic ingredient reimbursement rates that encourage efficient purchasing while being responsive to marketplace drug pricing fluctuations.

The goals and objectives of the DHCS MAIC pharmacy reimbursement program include, but are not limited to the following:

- Ensure MAIC rates are set in accordance with WIC Section 14105.45.
- Evaluate changes in drug product acquisition prices, the availability of generic drug products, brand drug loss of patent protection and update or establish MAIC rates as appropriate.
- Respond to changing circumstances in the drug marketplace that require action to MAIC rates including establishing, reviewing, adjusting, or suspending MAIC rates.
- Evaluate and respond to pharmacy provider MAIC rate inquiries based on current marketplace information, the provider's acquisition cost, and availability of the drug product.

4.6.3.2.1 MAIC Reimbursement Inquiry and Review Process

The intent of the MAIC rate inquiry and review process is to evaluate if the current MAIC rate for a specific product is reflective of current marketplace conditions.

The MAIC rate review will include an evaluation of product availability, drug shortages, changes in published pricing, and therapeutically equivalent generic products. The outcome of the MAIC rate review will be communicated to the provider and adjustments will be made to MAIC rates, as necessary.

Providers with concerns about specific MAIC rates may request a review of an MAIC rate for a specific drug by submitting a request. Required information for the MAIC review includes, but is not limited to the following:

- NDC
- Drug name and strength
- Package size
- Wholesaler
- Lowest attainable package price
- Claim DOS

- Quantity dispensed
- Reimbursement amount
- Current MAIC rate
- Invoice

The MAIC rate inquiry form can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information**. All required fields on the MAIC rate review form must be completed. Providers will be contacted for supporting documentation or other information, as necessary.

Providers can find MAIC rate lists on the [Mercer Medi-Cal Rx website](#) (<https://ca.mercerrxpassage.us/>). The Mercer Medi-Cal Rx website exclusively supports the Medi-Cal Rx MAIC program.

4.6.3.3 Federal Upper Limit (FUL)

The FUL is an upper-limit of reimbursement for certain multiple-source drugs established independently from the California MAIC program by CMS.

When a drug is listed on both the MAIC and FUL price lists, the maximum cost is the lower of the MAIC or FUL.

FUL drugs and prices are available on the CMS website at www.medicaid.gov.

4.6.4 Situations of Medical Necessity

When medically necessary for a specific member, approval of reimbursement at the NADAC or, if no NADAC, the WAC may be obtained for a product whose price exceeds the MAIC or FUL price limits by requesting a Price Override PA from a Medi-Cal Rx consultant. Reimbursement of the prescription ingredient cost may require the use of a brand of a multiple-source drug and may not exceed the statutory reimbursement limits.

Note: The situations of medical necessity price override does **not** apply to products classified as medical supplies or enteral nutrition products.

4.6.5 340B Pricing Program

Provider's billing drugs purchased pursuant to the 340B program (covered entities and contract pharmacies) are required to bill an amount not to exceed the entity's Actual Acquisition Cost (AAC) plus dispensing fee for the drug. Providers will be reimbursed the lesser of the billed amount (AAC plus Professional Dispensing Fee) or the maximum rate permitted.

4.6.6 Sales Tax

There is not a sales tax on prescriptions.

4.6.7 Compound Prescriptions

The maximum reimbursement for compounded prescriptions is the total of ingredient costs allowed under Medi-Cal Rx reimbursement policy, professional fees, compounding, and sterilization fees.

Compounds may be submitted for all media types (POS, batch, web, or paper).

Note: Medical supplies, diabetic supplies, enteral nutrition products, and blood factors may not be billed on a *California Specific Compound Pharmacy Claim Form* (30-4). The *California Specific Pharmacy Claim Form* (30-1) or UCF must be completed for non-compounded I.V. solutions. The (30-4) or UCF can be completed for compounded I.V. solutions or sterile transfers.

4.6.7.1 Compound (Injection/Infusion) Pricing

Compound pricing for injections and infusions (Ingredients + Compound Fee + Sterilization Fee + Professional Dispensing Fee) are calculated as follows:

Ingredient Cost = The sum of all the ingredients used in the compound.

- For each ingredient, the system-determined price quantity billed is multiplied by the applicable unit price for the price type in the appropriate algorithm.
- Each ingredient is calculated separately to determine whether the billed amount on the claim (that is, the Gross Amount Due [GAD]) or the system-determined price is the lesser of value; the lesser of value is then used.

Compounding Fee = The Container Count multiplied by a designated compounding fee for the given Route of Administration (ROA) (or Dosage Form, if applicable). The compounding fee must be billed in the "other amount claimed field" on the claim in order to receive reimbursement for a compounding fee. In addition, the Medi-Cal Rx vendor will evaluate the billed compounding fee to the calculated compounding fee and pay the lesser of the two amounts.

- Injection (as defined by ROA Systematized Nomenclature of Medicine (SNOMED) value = 424109004, 385218009 (Injection)) compounding fee is \$0.99 per container, with a maximum of 20 containers.
- Infusion (as defined by ROA SNOMED value = 424494004, C444364, XXX) compounding fee is \$0.99 per container, with a maximum of 20 containers without a PA.

Note: If a claim is submitted with greater than 20 containers on the claim, the claim will deny Reject Code 76 – Plan Limitations Exceeded. A PA can be submitted for an override.

Compounding fees and/or maximum containers may vary for a given timeframe.

Note: An approved PA may override the allowed number of containers used in the calculation.

If the ROA's compounding fee per container is equal to zero, then an alternate method of determining the compounding fee must be based on the Dosage Form.

Refer to [Section 4.6.7.3 – Compounding Fee Breakdown by Dosage Form](#) for additional information on Compounding Fees.

Dosage Form's compounding fees are based on low-end and high-end ranges that vary by dosage form.

Any compound claim billed which contains only the dummy NDC for containers, 99999999997, will be denied with Reject Code 7Z – Compound Requires Two or More Ingredients with the supplemental message “*Compounds with container NDC must also include at least one active compounded ingredient.*”

Sterilization Fee = The lowest amount between the billed Incentive Amount or the system-determined Sterilization Fee (using the following formula):

- Injection (as defined by ROA SNOMED value = 424109004, 385218009, XXX, XXX (Injection) sterilization fee is \$0.32 per container, with a maximum of 20 containers.
- Infusion (as defined by ROA SNOMED value = 424494006, C444364, XXX (Infusion) sterilization fee is \$0.32 per container, with a maximum of 20 containers.

If a claim is submitted with greater than 20 containers on the claim, the claim will deny Reject Code 76 – Plan Limitations Exceeded.

Sterilization fees and/or maximum containers may vary for a given timeframe.

The sterilization fees must be billed in the “incentive fee field” on the claim in order to receive reimbursement for the sterilization fee. In addition, the Medi-Cal Rx vendor will evaluate the *billed* sterilization fee to the *calculated* sterilization fee and pay the lesser of the two amounts.

Professional Dispensing Fee = Professional Dispensing Fee (defined in [Section 4.6.2 – Professional Dispensing Fee](#)) multiplied by Container Count, with a maximum of 20 containers.

Notes:

- Professional Dispensing Fees and/or maximum containers may vary for a given timeframe.
- Prior to April 1, 2017, the professional dispensing fee applied to compounds was a flat rate that varied based on place of services.

4.6.7.2 Compound (Non-Injection/Non-Infusion) Pricing

Non-Injection/Non-Infusion compound pricing (Ingredients + Compounding Fee + Sterilization Fee + Professional Dispensing Fee) are calculated as follows:

Ingredient Cost = The sum of all the Ingredients used in the Compound.

- For each ingredient, the system-determined price quantity billed is multiplied by the applicable unit price for the price type in the appropriate algorithm.
- Each ingredient is calculated separately to determine whether the billed amount on the claim (that is, the GAD) or the system-determined price is the lesser of value: the lesser of value is then used.

Compound Fee = The Container Count of 1 (regardless of what is included on the claim as the container count) multiplied by a designated compounding fee for the given ROA (or Dosage Form, if applicable).

- Nasal (as defined by ROA SNOMED value = 46713006 (Nasal)) compounding fee is \$0.81 per container.

- Ophthalmic (as defined by ROA SNOMED value = 54485002 (Ophthalmic)) compounding fee is \$2.04 per container.
- Otic (as defined as ROA SNOMED value = 1054007 (Otic)) compounding fee is \$0.81 per container.
- Buccal, Dental, Inhalation, Intraperitoneal, Irrigation, Mouth, Throat, Mucous Membrane, Oral, Other Misc., Rectal, Sublingual, Topical, Transdermal, Translingual, Urethral, Vaginal, Enteral (as the ROA) is determined by the Dosage Form.

The compounding fee must be billed in the “other amount claimed field” on the claim in order to receive reimbursement for a compounding fee. In addition, the Medi-Cal Rx vendor will evaluate the *billed* compounding fee to the *calculated* compounding fee and pay lesser of.

Any compound claim billed which contains only the dummy NDC for containers, 99999999997, will be denied with Reject Code 7Z – Compound Requires Two or More Ingredients with the supplemental message “*Compounds with container NDC must also include at least one active compounded ingredient.*”

Compounding fees and/or maximum containers may vary for a given timeframe.

Dosage Form’s Compounding Fees are based on low-end and high-end ranges that vary by the dosage form.

Sterilization Fee = Lowest amount between the billed Incentive Amount or the system-determined Sterilization Fee, using the following formula:

System-determined Sterilization Fee = Container Count of 1 (regardless of what is included on claim as the container count) multiplied by a designated sterilization fee for the given ROA.

- Intraperitoneal (as defined by ROA SNOMED value = 38239002 (Intraperitoneal)) sterilization fee is \$0.32 per container.
- Irrigation (as defined by ROA SNOMED value = 47056001 (Irrigation)) sterilization fee is \$0.32 per container.
- Mucous membrane (as defined by ROA SNOMED value = 419874009 (Mucous membrane)) sterilization fee is \$0.32 per container.
- Ophthalmic (as defined by ROA SNOMED value = 54485002 (Ophthalmic)) sterilization fee is \$0.32 per container.
- Urethral (as defined by ROA SNOMED value = 90028008 (Urethral)) sterilization fee is \$0.32 per container.
- Remaining Non-Injection/Infusion Compounds (Buccal, Dental, Inhalation, Mouth throat, Nasal, Oral, Other miscellaneous Otic, Rectal, Sublingual, Topical, Transdermal, Translingual, Vaginal, Enteral) sterilization fee is \$0.00.

Sterilization fees and/or maximum containers may vary for a given timeframe.

The sterilization fees must be billed in the “incentive fee field” on the claim in order to receive reimbursement for the sterilization fee. In addition, the Medi-Cal Rx vendor will evaluate the *billed* sterilization fee to the *calculated* sterilization fee and pay the lesser of the two amounts.

Professional Dispensing Fee = Professional Dispensing Fee (defined in [Section 4.6.2 – Professional Dispensing Fee](#)) multiplied by Container Count of 1 (regardless of what is included on the claim as the container count), with a maximum of 20 containers.

Notes:

- Professional Dispensing Fees and/or maximum containers may vary for a given timeframe.
- Prior to April 1, 2017, the professional dispensing fee applied to compounds was a flat rate that varied based upon place of service.

4.6.7.3 Compounding Fee Breakdown by Dosage Form

Note: The values below in *Table 4.6.7.3-1* are subject to change over time.

Compound Dosage Form	Compound Dosage Form Description	Compound Claim Quantity Low Range	Compound Claim Quantity High Range	Compounding Fee
01	CAPSULE	0000000	0000005	00.00
01	CAPSULE	0000006	0000036	01.98
01	CAPSULE	0000037	9999999	03.95
02	OINTMENT	0000000	0000000	00.00
02	OINTMENT	0000001	0000179	01.64
02	OINTMENT	0000180	9999999	03.29
03	CREAM	0000000	0000000	00.00
03	CREAM	0000001	0000179	01.64
03	CREAM	0000180	9999999	03.29
04	SUPPOSITORY	0000000	0000000	00.00
04	SUPPOSITORY	0000001	0000023	03.29
04	SUPPOSITORY	0000024	9999999	05.76
05	POWDER	0000000	0000005	00.00
05	POWDER	0000006	0000036	01.98
05	POWDER	0000037	9999999	03.95
06	EMULSION	0000000	0000000	00.00
06	EMULSION	0000001	0000239	00.81
06	EMULSION	0000240	9999999	01.64
07	LIQUID	0000000	9999999	00.99
10	TABLET	0000000	0000005	00.00
10	TABLET	0000006	0000036	01.98
10	TABLET	0000037	9999999	03.95

Compound Dosage Form	Compound Dosage Form Description	Compound Claim Quantity Low Range	Compound Claim Quantity High Range	Compounding Fee
11	SOLUTION	0000000	9999999	00.99
12	SUSPENSION	0000000	9999999	00.99
13	LOTION	0000000	0000000	00.00
13	LOTION	0000001	0000239	00.81
13	LOTION	0000240	9999999	01.64
14	SHAMPOO	0000000	9999999	00.99
15	ELIXIR	0000000	9999999	00.99
16	SYRUP	0000000	9999999	00.99
17	LOZENGE	0000000	0000005	00.00
17	LOZENGE	0000006	0000036	01.98
17	LOZENGE	0000037	9999999	03.95
18	ENEMA	0000000	9999999	00.99

Table 4.6.7.3-1: Compounding Fee Breakdown by Dosage Form

4.6.8 Drugs Provided to Physicians, Hospitals, Emergency Rooms, Outpatient Clinics, or Nursing Facilities for Dispensing or Administering

Pharmacies are not reimbursed by Medi-Cal Rx for either the cost of ingredients or the professional fee for drugs furnished to other providers to administer or dispense to members. Medi-Cal Rx does not consider this a pharmacy service rendered directly to Medi-Cal Rx members. Pharmacies that furnish drugs to the following providers should bill the provider directly:

- Physicians
- Hospital Emergency Rooms
- Outpatient Clinics
- Nursing Facilities – Pharmacies may bill Medi-Cal Rx for legend drugs and insulin for members in these facilities. All other drugs must be billed to the facility.

4.6.9 Nursing Facility Emergency Drug Supply

Pharmacies that own and maintain a nursing facility emergency drug supply may be reimbursed by Medi-Cal Rx for the ingredient cost and professional fee of a drug administered from the emergency drug supply for a nursing facility member's emergency condition as long as the use of the same drug is not continued after its administration from the emergency drug supply. However, when a drug is administered from the emergency drug supply to a nursing facility member for an emergency condition and the use of the same drug is continued after its

administration from the emergency drug supply, the pharmacy may be reimbursed by Medi-Cal Rx for a single prescription only after the total quantity of the prescription has been dispensed to the member.

4.6.10 Pharmacy Discounts

DHCS is aware that certain pharmacies engage in various advertising promotions that essentially result in some form of discount for their customers. Examples include, but are not limited to, the offering of price discounts, cash rebates, and free prescriptions.

Pharmacy providers offering such discounts to the general public must be available with the same terms and conditions to Medi-Cal Rx customers. Failure to do so may result in billing Medi-Cal Rx more than the usual and customary amount charged to the general public for the same service and is prohibited by CCR, Title 22, Sections 51480 and 51513(b)(1)(A), (c) and in accordance with Title 42, *Code of Federal Regulations*, Part 447.331.

4.6.11 Items Not Covered

Pharmacy items excluded from reimbursement under Medi-Cal Rx are:

- Common household items and remedies.
- Non-legend drug preparations:
 - Benzoic and Salicylic Acid Ointment (pre-compounded)
 - Salicylic Acid Cream or Ointment
 - Salicylic Acid Liquid
 - Sodium Chloride Tablets 1 gm
 - Sodium Chloride Tablets 2.5 gm
 - Zinc Oxide Paste
 - Non-legend analgesics except for those listed in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**).
- Medical food, enteral nutritional supplements, or replacements, except for items included in the [List of Contracted Enteral Nutrition Products](#) may be covered, subject to authorization.
- Oral OTC vitamin-mineral combination products for individuals older than 21 years of age, except those products listed in the [Medi-Cal Rx Contract Drugs List – Over-the-Counter Drugs and Cough/Cold Preparations](#).
- Oral legend vitamin-mineral combination products, excluding prenatal vitamin-mineral combinations intended for use during pregnancy.
- Non-legend OTC drugs except insulin are included in the NF-A and NF-B daily rates. Pharmacies will not be reimbursed for OTC drugs, other than insulin, for NF-A or NF-B patients.
- Medical supplies provided to inpatients receiving NF-A or NF-B services are reimbursable only for the medical supplies specified in [Section 8.2.1 – Long Term Care Claims Processing](#).

- Non-legend cough and cold drug products (except for those that meet the requirements found in the CDL).
- Extended-release OTC cough/cold preparations.

4.6.12 Continuing Care

Drugs that have been end-dated or suspended from the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**) will not be reimbursed unless a PA has been obtained for the drug or the member qualifies for continuing care. To be eligible for the PA exemption for continuing care, the following conditions must be met:

- The member must be taking the drug when it is end-dated or suspended from the CDL.
- The Medi-Cal Rx vendor must have received a claim for the drug, in the same dosage form and strength, within 100 days prior to the drug's suspension or deletion. The Medi-Cal Rx Provider Portal will allow a provider to look up a member and view that member's claims (only showing claims for the NPI of the provider who logged in). Any member claims history is only available via the Medi-Cal Rx Provider Portal after a provider has securely logged in.
- To maintain member eligibility under continuing care, a claim must be submitted for the drug in the same dosage, form, and strength within 100 days from the last DOS. The member may switch between brands of the drug in the same dosage form and strength and maintain their continuing care status.

4.6.13 Medical Supply Reimbursement

Medical supply reimbursement guidelines are as follows:

Net Purchase Price

Net purchase price is defined as the actual cost to the provider to purchase the item from the seller, including refunds, rebates, discounts, or any other price-reducing allowances, known by the provider at the time of billing Medi-Cal Rx for the item that reduces the item's invoice amount, pursuant to CCR, Title 22, Section 51008.1(a)(2)(A).

It shall reflect price reductions guaranteed by any contract to be applied to the item(s) billed to Medi-Cal Rx, pursuant to CCR, Title 22, Section 51008.1(a)(2)(B).

It shall not include provider costs associated with late payment penalties, interest, inventory costs, taxes, or labor, pursuant to CCR, Title 22, Section 51008.1(a)(2)(C).

Providers shall not submit bills for items obtained at no cost, pursuant to CCR, Title 22, Section 51008.1(b).

Upper Billing Limit

Claims for medical supplies should not exceed the amount that is the lesser of:

- The usual charges made to the general public.

- The net purchase price of the item (including all discounts and rebates), which shall be documented in the provider's books and records, plus no more than a 100 percent markup. Documentation shall include, but is not limited to including, evidence of purchase such as invoices or receipts.
- The Maximum Allowable Product Cost (MAPC) price on file for the item, plus a 23 percent dealer markup minus a 10 percent payment reduction for the following products:
 - Alcohol Prep Pads, Heparin and Normal Saline Flush solutions, Diaphragms and Cervical Caps, Condoms, Pen Needles, Sterile Syringes with Needles, and Miscellaneous Medical Supplies.
 - Effective July 1, 2022, the MAPC price on file for the item plus the appropriate professional dispense fee for the following products.
 - **Note:** A 10 percent payment reduction does NOT apply to these medical supplies:
 - DIDDs, CGM Systems, Peak Flow Meters, and Inhaler Assist Devices
- The MAPC price on file for the item plus the appropriate professional dispense fee minus a 10 percent payment reduction for the following products:
 - Diabetic Test Strips, Lancets, NDC-Billed Self-Monitoring Blood Glucose Systems, Control Solutions, Lancing Devices, and Insulin Syringes.

Maximum Reimbursement

The maximum amount reimbursed to providers is the lesser of:

- The amount billed.
- The MAPC price on file, plus a 23 percent dealer markup or appropriate professional dispensing fee (if applicable).

4.6.14 Enteral Nutrition Products Reimbursement

The amount reimbursed to providers for enteral nutrition products shall not exceed the published Estimated Acquisition Cost (EAC) plus a 23 percent markup (W&I Code, Section 14105.85) minus a 10 percent reduction (W&I Code, Section 14105.192).

Refer to the *List of Contracted Enteral Nutrition Products* (found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**) for the published EAC.

4.6.15 Providers Payment Reduction

The reimbursements described in this manual may be subject to reductions or supplements to provider payments required by state law, such as the 10 percent reductions required by W&I Code, Section 14105.192.

Note: Effective July 1, 2022, provider payment reductions will no longer be applied to the following products:

- CGM Systems (refer to [Section 13.4 – Personal Home Blood Pressure Monitors and Cuffs](#) for information on coverage)

- Inhaled Assisted Devices
- Peak Flow Meters
- DIDDs (refer to [Section 13.3 – Diabetic Supplies – CGM Systems](#) for information on coverage)

4.6.16 Blood and Blood Derivatives Reimbursement

Blood factor reimbursement is based on the lesser of:

- The manufacturer's reported Average Sales Price (ASP), plus 20 percent; **OR**
- The provider's billed AAC + applicable professional dispensing fee.
 - Claims submitted by federally recognized Hemophilia Treatment Centers (HTC) must use the AAC for the drug as defined in W&I Code, Section 14105.46, plus a professional dispensing fee of \$0.14 per unit.
 - Claims submitted by all other providers must use the AAC for the drug equal to the invoice price minus any discounts (excluding a prompt pay discount of less than or equal to 2 percent), rebates, or chargebacks, plus a professional dispensing fee of \$0.04 per unit.

Note: It will be up to the submitting pharmacy to submit the billed amount on the claim utilizing their correct AAC and the appropriate professional dispensing fee.

For reference, the ASP is the amount reported to the federal CMS by the manufacturer pursuant to Section 1847A of the federal Social Security Act (42 USC, Section 1395w-3a).

4.6.17 Prescription and OTC Smoking/Tobacco Cessation Products for Use During Pregnancy

Med-Cal will provide coverage of prescription and OTC smoking/tobacco cessation covered outpatient drugs for pregnant women as recommended in "Treating Tobacco Use and Dependence – 2008 Update: A Clinical Practice Guideline" published by the United States Public Health Service in May 2008 or any subsequent modification of such guideline.

Although the Patient Protection and Affordable Care Act (ACA) Section 4107 authorizes coverage of counseling and pharmacotherapy for tobacco cessation for pregnant women, the United States Preventive Services Task Force concludes that the current evidence is insufficient to assess the balance of benefits and harms of pharmacotherapy interventions for tobacco cessation in pregnant women. Providers should refer to the tobacco cessation guidelines by the American College of Obstetricians and Gynecologists (ACOG) before prescribing tobacco cessation medications during pregnancy.

Prescription and OTC smoking/tobacco cessation products for pregnant women are covered via the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#) and then **Covered Products Lists**) or via PA.

4.6.18 >>Vaccine Administration Fee

>>All vaccines eligible for pharmacy reimbursement under Medi-Cal Rx are pursuant to the guidelines published by the Centers for Disease Control and Prevention (CDC) for members 19 years of age and older.

>>For claims submitted with a DOS *on or after* January 1, 2024, Medi-Cal Rx will reimburse the pharmacy provider for the ingredient cost, professional dispensing fee, and professional services administration fee when a pharmacy provider submits for reimbursement of a vaccine.

>>To receive the professional services administration fee, the pharmacy provider must identify that the pharmacy is administering the vaccine and enter the applicable values in the following NCPDP fields:

- Enter the dollar amount of the administration fee in the Incentive Fee Amount Submitted field (NCPDP Field ID: 438-E3).
- Select the following Reason for Service Code (NCPDP Field ID: 439-E4):
 - PH = Preventive Health Care
- Select the following Professional Service Code (NCPDP Field ID: 440-E5):
 - MA = Medication Administration
- Select the following Result of Service Code (NCPDP Field ID: 441-E6):
 - 3N = Medication Administration

>>Reimbursement

>>Reimbursement of pharmacy claims submitted to Medi-Cal Rx is outlined as follows:

- >>Ingredient cost (refer to [Section 4.6.1 – Legend and Non-Legend Drugs](#) for reimbursement information)
- >>Professional dispensing fee (refer to [Section 4.6.2 – Professional Dispensing Fee](#) for fee amount)
- >>Administration fee:
 - >>DHCS will reimburse the lesser of the billed amount of \$15.95 for the professional services associated with the administration of a vaccine.
- **>>For retroactive pharmacy claims with a DOS on or after January 1, 2022, through December 31, 2023**, Medi-Cal Rx will reimburse pharmacy providers the lesser of the billed amount of \$3.79 for the professional services associated with the administration of a vaccine. Information in this section about NCPDP required fields, ingredient cost, and professional dispense fees also applies to these retroactive claims.

>>**Note:** The vaccine administration fee is different from the VFC program. Refer to [Section 15.9.1 – Vaccines For Children Program](#) for additional information.

4.7 Filing Limitations

4.7.1 Timely Filing Limitations

POS claims are generally submitted at the time of dispensing. However, there may be circumstances that require a claim to be submitted retroactively. Refer to *Table 4.7.1-1* for claim filing limits.

Claims that exceed the maximum filing limit, as indicated below, will deny with Reject Code 81 – Timely Filing Exceeded. Providers may request an override by contacting the CSC at 1-800-977-2273.

Note: These limits will utilize the Adjudication Date and DOS. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Type Description/ Transaction Description	Filing Limit	Comments
B1 = original claim	365 days	Claims exceeding the maximum filing limit of 365 days will deny with Reject Code 81 – Timely Filing Exceeded Note: May be subject to Timely Filing Claim Cutback, refer to Section 4.7.3 – Timely Filing Claim Cutback .
B2 = reversal	Unlimited	No filing limitations for B2 (reversal) transaction.
B3 = rebill	365 days	Claims exceeding the maximum filing limit of 365 days will deny with Reject Code 81 – Timely Filing Exceeded Note: Claims may be subject to Timely Filing Claim Cutback, refer to Section 4.7.3 – Timely Filing Claim Cutback .
Requests for timely filing overrides		All requests for Timely Filing Overrides will be reviewed.
Timely Filing Cutback		For full reimbursement, claims must be submitted to Medi-Cal Rx within 6 months (known as the 6-month Billing Limit) following the month of the DOS of the claim. If claims are not received within the 6-month time window, claims reimbursement will be cutback/reduced. For additional information refer to Section 4.7.2 – Six-Month Billing Limit and Section 4.7.3 – Timely Filing Claim Cutback .

Table 4.7.1-1: Claim Filing Limits

4.7.2 Six-Month Billing Limit

For full reimbursement, claims must be submitted to Medi-Cal Rx within 6 months following the month of the DOS of the claim. This requirement is referred to as the six-month billing limit. Refer to *Table 4.7.2-1*.

For example, if services are provided on April 15, the claim must be received by the Medi-Cal Rx vendor prior to October 31 to avoid payment reduction (refer to [Section 4.7.3 – Timely Filing Claim Cutback](#)) or denial for late billing.

If the Date of Service is in this month:	Then Claims must be received by the last day of this month:
JANUARY	JULY
FEBRUARY	AUGUST
MARCH	SEPTEMBER
APRIL	OCTOBER
MAY	NOVEMBER
JUNE	DECEMBER
JULY	JANUARY
AUGUST	FEBRUARY
SEPTEMBER	MARCH
OCTOBER	APRIL
NOVEMBER	MAY
DECEMBER	JUNE

Table 4.7.2-1: Six-Month Billing Limit

Exceptions to Six-Month Billing Limit

Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the delay reasons allowed by regulations (refer to the *Over-One-Year Billing Exceptions* table in [Section 19.3.1 – Submission and Timeliness Instructions](#)). Delay reason codes are used on claims to designate approved reasons for late claim submission. These delay reasons (submission of a CIF, submission of Appeal) also have time limits as seen in *Figure 4.7.2-1* below. Exceptions with required documentation are required to be submitted via paper (refer to [Section 19.0 – Claim Forms](#) and applicable subsections).

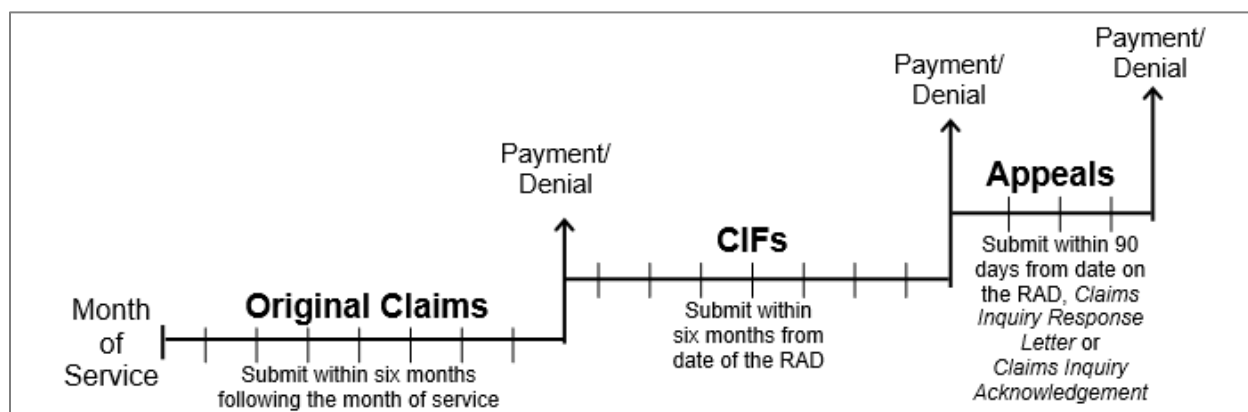


Figure 4.7.2-1: Claim Timeline Chart

4.7.3 Timely Filing Claim Cutback

Claims that are not received by Medi-Cal Rx within the six-month billing limit and do not have an approved exception will be reimbursed at a reduced rate or will be denied as follows:

- Claims received during the 7th through the 9th month after the month of service will be reimbursed at 75 percent of the payable amount.
- Claims received during the 10th through 12th month after the month of service will be reimbursed at 50 percent of the payable amount.
- Claims received after the 12th month following the month of service will be denied.

5.0 Medi-Cal Rx Provider Claim Appeal Processes

A claim appeal is the final step in the administrative process. The appeal process offers Medi-Cal Rx providers a method for resolving problems related to their claim disputes. Each claim will be reviewed on its own merit, using applicable history files and documentation that the provider presents with the appeal, which will allow a fair decision to be rendered.

The Medi-Cal Rx Provider Claim Appeal process is only applicable to pharmacy FFS claims processed by Medi-Cal Rx or by CA-MMIS.

5.1 Preparing a Claim Appeal

An appeal must be submitted on a *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) (refer to [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information). The form can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#). Resubmission, underpayment, and overpayment requests for the same member may be combined on one form. However, each appeal should include only **one member**.

The provider must identify the claim(s) involved and specifically describe the disputed action or inaction regarding each claim.

The *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) can be mailed to the Medi-Cal Rx Claims Department (refer to [Appendix B – Directory](#) for the mailing address).

Providers may file a second appeal within 90 days from the initial appeal if the following apply:

- The Medi-Cal Rx Claim Appeal Team fails to act.
- The Medi-Cal Rx Appeal Acknowledgement Letter has not been sent from the Medi-Cal Rx Claim Appeal Team within fifteen (15) days of receipt of the appeal.
- The provider is dissatisfied with the action taken by the Medi-Cal Rx Claim Appeal Team regarding that appeal.

The Medi-Cal Rx Claim Appeal Team accepts appeals related to pharmacy claim processing issues only. Appeals for Medi-Cal Rx-related items that do *not* pertain to pharmacy claim processing (such as member eligibility determination and provider enrollment) must be submitted to the appropriate state or county department.

5.2 Claim Appeal Timeliness

5.2.1 90-Day Deadline

Providers must submit an appeal within 90 days of the action/inaction precipitating the complaint. Failure to submit an appeal within this 90-day time period will result in the appeal being denied. Refer to CCR, Title 22, Section 51015.

5.2.2 Over-One-Year Dates of Service

Appeals submitted for claim billing services rendered more than 13 months prior to the appeal date should include one of the following, if available, to show proof of recipient eligibility:

- Copy or screen print of the Medi-Cal Rx Claim Appeal Team's Member Eligibility Lookup Tool (refer to [Section 8.0 – Member Eligibility](#) for additional information) response.
- RA showing payment for same member for the same month of service billed.
- Copy of the original *County Letter of Authorization (LOA)* form (MC-180) signed by an official of the county.

5.2.3 Timeliness Verification

The Medi-Cal Rx Claim Appeal Team will **only** accept the following documents to verify the timely submission of a claim:

- A copy of an RA.
- A Medi-Cal Rx Claim Inquiry Response Letter.
- A Medi-Cal Rx Claim Inquiry Acknowledgement Letter.
- Any dated correspondence from the Medi-Cal Rx Claim Appeal Team with a date falling within the six-month billing limit for claim submission.

Note: A copy of the CIF **without** its accompanying *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* does **not** prove timely follow-up and may cause an appeal to be denied.

5.3 Reasons for a Claim Appeal

The following are three common reasons for an appeal:

- Eligibility – There was a Medi-Cal Rx claim denial due to member eligibility.
- Crossover – There was a Medi-Cal Rx crossover claim denial, overpayment, or underpayment.
- Adjustment Request – There was a Medi-Cal Rx claim overpayment or underpayment.

The above options are available in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) (refer to [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information on the form). If a provider is submitting a claim appeal for any reason other than the above options, this must be explained in the provided lines of *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

5.4 Supporting Documentation for a Claim Appeal

Necessary documentation, such as those listed below, should be submitted with each appeal to help the Medi-Cal Rx Claim Appeal Team perform a thorough review of the appeal. All supporting documentation must be legible. A copy of any of the following attachments is acceptable:

- Corrected claim (if necessary).
- RAs pertaining to claim history.
- Explanation of Medicare Benefits (EOMB) or Medicare Remittance Notice (MRN).
- OHC payments or denials.
- All CIFs, Medi-Cal Rx Claim Inquiry Acknowledgement Letters, Medi-Cal Rx Claim Inquiry Response Letters, or other dated correspondence to and from the Medi-Cal Rx Claim Appeal Team documenting timely follow-up.
- PA request(s).
- Copy of POS printout or internet eligibility response attached to the claim.
- If there is no record of an adjudicated claim found for a CIF Tracer, the provider should attach the CIF Tracer, Medi-Cal Rx Tracer No Hit Letter, and any additional supporting documentation.

Each appeal **must** contain proof of timeliness. Refer to [Section 5.2 – Claim Appeal Timeliness](#) and corresponding subsections for acceptable documentation to verify timely submission.

Note: In cases where a CIF has been filed prior to an appeal, the provider has one year from the date of the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* to file an appeal if no action resulted from the CIF. The *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* **must** be submitted with the appeal; if it is not, the 90-day rule applies. If the 90-day timeline is not met, the appeal is subject to denial.

5.5 Acknowledgement of Appeal

The Medi-Cal Rx Claim Appeal Team will acknowledge each appeal within 15 days of receipt and make a decision within 30 days of receipt. If a decision is not made within 30 days, the appeal is referred to the professional review unit for an additional 30 days.

If the appealed claim is approved for reprocessing, it will appear on a future RA as a claim (the claim will be reprocessed using the same prescription number and member ID from the appeal request). The reprocessed claim will continue to be subjected to Med-Cal Rx policy and claim processing criteria and could also be denied for a separate reason.

Medi-Cal Rx will send a letter of explanation in response to each appealed claim. Providers who are dissatisfied with the decision may submit subsequent appeals. In these cases, indicate the reason for appealing the decision in the *Part 3 – Appeal Reason* field of the form and attach a copy of the claim and any supporting documentation (including timeliness documentation).

5.6 Judicial Remedy: One-Year Limit

Providers who are not satisfied with Medi-Cal Rx's decision after completing the appeal process may seek relief by judicial remedy **not later than one year** after the appeal decision. Providers who elect to seek judicial relief may file a suit in a local court, naming DHCS as the defendant. Refer to W&I Code, Section 14104.5.

6.0 Service Provider (Pharmacy ID) and Prescriber ID

6.1 Service Provider (Pharmacy ID)

Service Providers must submit the NPI number on all claims. If the service provider qualifier ID is not equal to '01,' the claim will be denied with Reject Code B2 – M/I Service Provider ID with the supplemental message *"NPI must be submitted."*

Sanctioned Service Providers – If a service provider has been sanctioned, claims will deny with Reject Code 559 with the supplemental message *"Pharmacy is Sanctioned. No claims allowed for Pharmacy."*

6.2 Prescriber ID

Pharmacies must submit the NPI number for the prescriber on all claims. If the prescriber qualifier is not equal to "01 – NPI" the claim will deny with Reject Code 25 – M/I Prescriber ID.

Note: The Prescriber NPI *cannot* equal the Service Provider NPI on claims.

Sanctioned Prescribers – If a prescriber is sanctioned, claims will reject with Reject Code A1 – ID Submitted Associated with a Sanctioned Prescriber with the supplemental message *"Prescriber is Sanctioned. No claims allowed for Prescriber."*

7.0 Provider Procedure/Drug Code Limitation (P/DCL)

In accordance with SB 857 and W&I Code, Section 14044, a Procedure/Drug Code Limitation (P/DCL) may be imposed on a provider's use of one or more codes (CPT®, NDC, or HCPCS) for a period of up to 18 months, if one of the following conditions exists:

- DHCS determines, by audit or other investigation, that excessive services, billings, or abuse have occurred by a provider.
- A provider's licensing authority or a court of competent jurisdiction limits a licensee's practice of medicine, where the limitation precludes the licensee from performing services that could otherwise be reimbursed.

A provider placed on P/DCL sanction will not be able to receive reimbursement for those services under restriction. In addition, providers who fill orders for lab tests, drugs, medical supplies, or any other restricted services prescribed or ordered by a provider under restriction will not be reimbursed.

The limitation becomes effective after DHCS gives the provider notice of the proposed limitation and no appeal is submitted within 45 days or following the denial of an appeal.

DHCS reviews provider appeal evidence and issues the appeal decision within 45 days of receipt. If the appeal is not granted, the code-use limitations become effective 15 days after provider notification.

In a situation where the sanction could interfere with the provider's or other prescriber's ability to render health care services to a member, the burden to transfer the member's care to another qualified provider remains the responsibility of the provider.

The P/DCL may be used separately or in tandem with other existing anti-fraud and abuse efforts.

Specific information on procedure/drug code limitations will be added to this manual as it becomes available.

Pharmacy claims that are submitted where the *prescriber* is placed on a P/DCL sanction will deny with Reject Code 71 – Prescriber ID is Not Covered with the supplemental message "*Prescriber is sanctioned from prescribing certain or all drugs.*"

Pharmacy claims that are submitted where the *pharmacy* is placed on a P/DCL sanction will deny with Reject Code 70 – Product/Service not covered with the supplemental message "*Pharmacy is sanctioned from dispensing certain or all drugs.*"

8.0 Member Eligibility

Member eligibility can be validated via several methods:

- CSC
 - Nationwide Toll-Free Number: 1-800-977-2273

- [Medi-Cal Rx Secured Provider Portal](#)
 - Once a provider has logged in, the Member Eligibility Lookup Tool will be available under Tools & Resources (refer to [Section 3.6.1.2.4 – Additional Resources](#) and [Section 10.3.2 – Identifying Member's OHC via Member Eligibility Lookup Tool](#)).
- Eligibility Verification via NCPDP E1 Transaction

Member Identification: Provider Obligations

When a provider verifies that an individual is eligible to receive Medi-Cal Rx benefits, the provider is accepting the individual as a Medi-Cal Rx member. The provider is then bound by the rules and regulations governing Medi-Cal Rx regarding that member. If the provider is unwilling to accept an individual as a Medi-Cal Rx member, the provider has no authority to access confidential eligibility information.

Note: To receive reimbursement, the member *must* be eligible for Medi-Cal Rx FFS on the DOS. This also applies to Medi-Cal Rx claims for members enrolled in CCS, GHPP, or Family PACT.

8.1 Identification Numbers, Cards, and Claims

8.1.1 Beneficiary ID

Refer to *Table 8.1.1-1* for information regarding the format of both the BIC ID and Health Access Programs (HAP) ID.

Description	Format	For Submission Purposes
BIC ID		Fourteen Characters
HAP ID	Eight numbers then a letter Note: These IDs begin with the number 9 and end with either an 'X' or 'Y'	Nine Characters

Table 8.1.1-1: BIC and HAP ID Information

Each Medi-Cal Rx member will have their own unique ID number.

The BIC ID is on the member's card and is 14 alpha-numeric characters. For claim submission, the pharmacy can submit the first 9 characters of the BIC ID, or the full 14 characters on the claim.

Note: For pharmacies submitting claims for same-day, newly enrolled Medi-Cal members, the full 14-character BIC ID **must be entered** on the claim for services rendered on the enrollment date.

Altered ID Cards

Medi-Cal Rx ID cards must **not** be altered by either the member or provider. If a member presents a card that is photocopied or contains erasures, strikeouts, white-outs, typeover, or any other form of alteration, providers should request that the member obtain an unaltered card and check other identification to ensure the patient is the Medi-Cal Rx member. Do not accept altered Medi-Cal Rx cards as proof of eligibility.

8.1.2 BIC ID

Each member is issued a BIC, which can be in one of the following formats:

- Plastic Benefits Identification Card
- Paper ID Card
 - In exceptional situations, county welfare departments may issue temporary paper cards to individuals.

8.1.3 HAP Card ID

Providers are furnished with plastic, prenumbered, teal-colored cards to distribute to members at the time of their first service so there is no delay in care. Because a member's HAP identification number is entered at a provider's site in real-time through the POS network, a provider can render services and submit a claim for reimbursement without delay.

An activated plastic HAP card offers access to program-specific medical, laboratory and pharmacy services by referral from the member's physician.

Note: Members can have both types of identification cards and applicable services associated with each card.

8.2 Special Eligibility/Client Conditions

The following populations in *Table 8.2-1* exist in Medi-Cal Rx:

Description	Identified By	Details
Hospice	Restriction code in Medi-Cal Eligibility Data System (MEDS).	There are no differences to claims processing for Hospice. All rules/edits apply.
Pregnancy/Postpartum	N/A	There are no claims processing differences. All rules/edits apply.
Long Term Care (LTC)	Claim(s) submitted with Patient Residence = 3 – Nursing Facility or 9 – Intermediate Care Facility/Individuals with Intellectual Disabilities	Refer to Section 8.2.1 – Long Term Care Claims Processing .

Description	Identified By	Details
Newborn	Claim(s) submitted with Relationship Code = 03 Dependent & PA Type Code = '8'	<p>There are no claims processing differences.</p> <p>Newborns are covered under their mother's Medi-Cal Rx ID for the 1st month of birth to the end of the following month (up to 60 days).</p> <p>Newborn claims are submitted under the mother's Medi-Cal ID.</p> <p>All drug coverage rules/edits apply.</p> <p>Refer to Section 8.2.2 – Newborns.</p>
Family Planning Services	HAP ID and Aid Code 8H	<p>Family PACT members have different coverage. Refer to Section 8.2.4 – Family Planning, Access, Care, and Treatment (Family PACT).</p>
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)		<p>Members that are younger than 21 and have Full Scope coverage are EPSDT eligible.</p>
CCS		<p>Refer to Section 8.2.5 – California Children's Services (CCS) Program & Genetically Handicapped Persons Program (GHPP).</p>
GHPP		<p>Refer to Section 8.2.5 – California Children's Services (CCS) Program & Genetically Handicapped Persons Program (GHPP).</p>
Programs of All-Inclusive Care for the Elderly (PACE) Managed Care Plan (MCP)		<p>All claims deny with Reject Code AF-Patient Enrolled Under Managed Care with the supplemental message "Please resubmit to PACE XXX Plan."</p> <p>Note: XXX will have a numeric value corresponding to the plan number.</p>

Description	Identified By	Details
Cal MediConnect MCP		<p>All claims deny with Reject Code AF-Patient Enrolled Under Managed Care with the supplemental message <i>"Please resubmit to Cal MediConnect XXX Plan."</i></p> <p>Note: XXX will have a numeric value corresponding to the plan number.</p>
SCAN (Senior Care Action Network) MCP		<p>All claims deny with Reject Code AF-Patient Enrolled Under Managed Care with the supplemental message <i>"Please resubmit to SCAN XXX Plan."</i></p> <p>Note: XXX will have a numeric value corresponding to plan number.</p>

Table 8.2-1: Special Eligibility/Client Conditions in Medi-Cal Rx

8.2.1 Long Term Care Claims Processing

Long Term Care (LTC) members will be identified via the 'Patient Residence' claim field. A submitted value of '3' – Nursing Facility or '9' – Intermediate Care Facility/Individuals with Intellectual Disabilities will identify the member as LTC.

All PA, CDL, and ProDUR edits will apply.

OTC products, *except for **Insulin***, are excluded from coverage as they should be provided by the facility.

Medical supplies provided to inpatients receiving Nursing Facility Level A (NF-A) Services or Nursing Facility Level B (NF-B) services, whether or not rendered in a hospital setting (CCR, Title 22, Sections 51510 and 51511), are separately reimbursable only for the medical supplies listed below and only when required by a specific patient for that patient's exclusive use.

- Diabetic testing supplies, specific to the published *List*
- Self-monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices specific to the published *List*
- DIDDs (PA only) specific to the published *List*
- CGM Systems (PA only)
- Condoms
- Diaphragms
- Infusion Supplies – Heparin and Saline Flush

Note: Information regarding *Outpatient Hemodialysis, Nursing Facilities: Supplies Limited Use, Inpatient Hospital Services, or Supplies for Rented DME* can be found in the *Medical Supplies* section of the [DHCS Provider Manual \(Part 2\)](#).

There are no differences in claims processing when the member is in Hospice care *in addition to* LTC.

All services must be rendered in accordance with Medicare requirements.

8.2.2 Newborns

Newborn members will be covered under their mother's Medi-Cal ID number for the first month of birth to the end of the following month (up to 60 days). After this time, the infant must have their own Medi-Cal ID number.

Newborns will be identified via the Relationship Code and PA Type Code (PATC). A submitted value of '03' – Dependent and a PATC value of '8' will identify the member as a Newborn.

All drug coverage rules and edits found in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**) will still apply for Newborn members.

8.2.3 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

In California, the Child Health and Disability Prevention (CHDP) program administers the screening component of the federally mandated EPSDT benefit for individuals younger than the age of 21. The standards to meet medical necessity differ between Medi-Cal and EPSDT. The EPSDT standard is as follows:

EPSDT services are medically necessary or a medical necessity if they correct or ameliorate defects and physical and mental illnesses and conditions discovered through screening. This standard is set forth in Title XIX of the Social Security Act, Section 1905(r)(5) and in *Welfare and Institutions Code* (W&I Code), Section 14059.5(b)(1).

Pharmacy claims submitted to Medi-Cal Rx for certain products not covered by Medi-Cal may be covered under EPSDT with an approved PA for members younger than the age of 21 and with full scope Medi-Cal.

8.2.4 Family Planning, Access, Care, and Treatment (Family PACT)

The Family PACT services are designed to support contraceptive needs of women and men, as well as assistance with family planning-related services to achieve and maintain optimal reproductive health.

The Family PACT program covers contraceptive drugs, devices, and supplies, and drugs for the treatment of specified sexually transmitted infections (STIs) and urinary tract infections (UTIs).

Quantity and frequency limitations apply as noted in the [Medi-Cal Rx Family Planning, Access, Care, and Treatment Pharmacy Formulary](#) found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.

All Medi-Cal Rx drug coverage edits apply to the Family PACT program, in addition to program-specific edits with one exception. Compounds are **not** a covered benefit of the Family PACT program. These claims will deny with Reject Code 7Y – Compounds Not Covered with the supplemental message *"Compounds are not a covered benefit of FPACT."*

8.2.4.1 Family PACT Pharmacy Billing Overview

Pharmacy Dispensing: Medi-Cal Rx pharmacy providers may bill Family PACT for the U.S. Food and Drug Administration (FDA)-approved drugs and medical supplies that are included in the [Medi-Cal Rx Family Planning, Access, Care, and Treatment Pharmacy Formulary](#) and are prescribed by an enrolled Family PACT provider or associated practitioner, or an enrolled Medi-Cal provider (when the client is referred by an enrolled Family PACT provider). The [Medi-Cal Rx Family Planning, Access, Care, and Treatment Pharmacy Formulary](#) can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.

No Enrollment Necessary for Medi-Cal Pharmacy Providers: Medi-Cal pharmacy providers are not required to enroll in the Family PACT program. In addition, pharmacy providers are not required to attend a Provider Orientation in order to be reimbursed for services rendered to Family PACT clients.

WCS/POS System: It is recommended that pharmacies use the WCS method or submit claims via POS for all Family PACT pharmacy billing transactions.

Reimbursement Rate: The reimbursement rates for Family PACT drugs and contraceptive supplies dispensed at pharmacies are the same as those for the Medi-Cal program (refer to [Section 4.6 – Reimbursement](#) for additional information).

Codes for Contraceptives: Pharmacists must bill the following contraceptive supplies using a National Drug Code (NDC):

- Condoms (internal and male)
- Diaphragms
- Cervical Caps
- Basal thermometers
- Lubricating jelly
- Spermicides and vaginal films

8.2.4.2 Family PACT Prior Authorization(s)

All drugs to manage a preselected complication of a Family PACT benefit require authorization using a PA request (refer to [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#) for additional information). Drugs needed to treat complications are limited to drugs and supplies identified in the [Medi-Cal Rx Family Planning, Access, Care, and](#)

[Treatment Pharmacy Formulary](#) (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**).

Use of Authorized Labelers: For the list of current authorized labelers, refer to the [Medi-Cal Rx Contract Drugs List – Authorized Drug Manufacturer Labeler Codes](#) on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**.

8.2.5 California Children’s Services (CCS) Program and Genetically Handicapped Persons Program (GHPP)

All CCS-only and GHPP-only services require a PA.

The CCS program provides health care services, including diagnostic, treatment, dental, administrative case management, physical therapy, and occupational therapy services, to children from birth up to 21 years of age with CCS-eligible medical conditions.

The GHPP provides health care services for members aged 21 years and older with specific genetic diseases. However, members younger than 21 years of age with a GHPP eligible medical condition that do not qualify for GHPP may be eligible for the program. For more information, refer to the [GHPP website](#).

As mentioned in [Section 10.0 – Coordination of Benefits \(COB\)](#), Medi-Cal Rx is always the payer of last resort. Providers are required to bill a CCS or GHPP member’s OHC prior to billing the CCS program or GHPP.

Pharmacy claims for CCS-only, GHPP only, CCS/Medi-Cal Rx and GHPP/Medi-Cal Rx members may be submitted electronically either using the POS system, or web-claim submission/direct-data entry billing or manually via *Pharmacy Claim Form* (30-1) or the UCF (refer to [Section 19.0 – Claim Forms](#) and its subsections for additional information on completion of forms and tips for billing).

For dates of service prior to January 1, 2022

- Claims for members in CCS Whole Child Model (WCM) are completely carved into an MCP and are identified and processed exactly like all other MCP members with the exception of Blood Factors and specified clotting disorder treatments, which are processed as FFS.
- Claims for members not in an MCP are processed as an FFS claim.

For dates of service on or after January 1, 2022

- All CCS-only and GHPP-only services require a PA request.
 - CCS-only will process according to CCS policy.
 - GHPP-only will process according to GHPP policy.
- CCS/Medi-Cal and GHPP/Medi-Cal member claims will process according to Medi-Cal FFS policy. Services not covered by Medi-Cal may be eligible for a PA under the CCS or GHPP.

8.2.5.1 General CCS Requirements

In order to provide products to a CCS-only member for a CCS condition, or condition secondary to a CCS condition (defined below), a CCS paneled provider must prescribe it.

A list of CCS covered medical conditions can be found on the following website:

<https://www.dhcs.ca.gov/services/ccs/Pages/medicaleligibility.aspx>.

Secondary to CCS Condition

Conditions that are secondary to CCS conditions are interpreted as CCS conditions for the purposes of CCS policy. A PA will be required and will evaluate the secondary conditions for applicability to one or more CCS conditions.

CCS Paneled Providers (Prescribers)

"Paneled Providers" have been determined by the CCS program to meet the advanced educations, training, and/or experience requirements for their provider type in order to render services to a CCS applicant or member. Listings and files for "Paneled Providers" are available at <https://www.dhcs.ca.gov/services/ccs/Pages/CCSProviders.aspx>.

8.2.5.1.1 CCS Prior Authorization Requirements

The following PA requirements apply for CCS-only or CCS/Medi-Cal members:

- CCS-only Policy: In order to provide the drugs/supplies that require a PA for CCS, a CCS paneled provider must prescribe it. The prescriber or pharmacy will complete the request for PA.
- CCS/Medi-Cal Policy: In order to provide the drugs/supplies that require a PA for CCS, a CCS paneled provider must prescribe it. The prescriber or pharmacy will complete the request for PA.
- Medi-Cal Policy (including EPSDT): If PA is required for drugs/supplies, evaluate per medical necessity.

For additional information regarding PA submission methods refer to [*Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication*](#).

8.2.5.1.2 Special Care Center Required Prior Authorizations

The following PA requirements apply for CCS members as they pertain to Special Care Centers:

- CCS-only Policy: In order to provide the following products to a CCS member, a CCS Special Care Center Provider must complete a PA. If the drug is oral, it is preferred if the pharmacy submits the PA, with the Special Care Center providing justification.
- CCS/Medi-Cal Policy: In order to provide the following products to a CCS member, a CCS Special Care Center Provider must complete a PA. If the drug is oral, it is preferred if the pharmacy submits the PA, with the Special Care Center providing justification.

Refer to *Table 8.2.5.1.2-1* for the current list of drugs requiring prescription by a CCS Special Care Center or subspecialist:

Drug	Special Care Center/ Specialist Requirement
Cerliponase Alfa (Brineura)	Special Care Center
Voretigene Neparvovec-rzyl (Luxturna)	CCS-paneled retinal specialist
Palynziq (pegvaliase-pqpz)	Special Care Center (REMS)
Tisagenlecleucel (Kymriah)	Special Care Center (REMS)
Kalydeco, Orkambi, Symdeko, Trikafta	Special Care Center
Gn RH agonist (Lupron, Histrelin acetate, Triptorelin pamoate)	CCS paneled endocrinologist
Epidiolex	CCS paneled neurologist
Nusinersen	Special Care Center
Botulinum toxin	CCS paneled neurologist or physiatrist

Table 8.2.5.1.2-1: Drugs Requiring CCS Special Care Center Prescription

8.2.5.2 General GHPP Requirements

All GHPP-only services require Prior Authorization.

For additional information regarding PA submission methods refer to [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#).

For GHPP-only members, the prescriber does *not* have to be a CCS paneled provider and does *not* need to treat a CCS condition nor a GHPP condition, as GHPP provides comprehensive coverage (for example, if an individual is enrolled in GHPP all services for that individual are covered, not just services for the GHPP condition). Eligibility requires only that the member has a diagnosis of a GHPP eligible condition.

A list of GHPP covered medical conditions can be found on the following website:

<https://www.dhcs.ca.gov/services/ghpp/Pages/MedicalEligibility.aspx>.

8.2.5.3 CCS Program County Office Directory

The CCS county office directory

(<https://www.dhcs.ca.gov/services/ccs/Pages/CountyOffices.aspx>) identifies the CCS county offices as dependent or independent, and which state offices are responsible for the county providing their administrative oversight.

The following guidelines may be helpful in selecting the correct office:

- For questions about eligibility, contact the CCS independent county office.

- For questions about eligibility (residential eligibility or financial questions) in dependent counties, contact the CCS dependent county office.

8.2.6 Managed Care Plans (MCPs)

As of January 1, 2022, Medi-Cal Rx has taken over the responsibility from Medi-Cal MCPs for administering the following **when billed by a pharmacy on a pharmacy claim:**

- Covered Outpatient Drugs, including PADs
- Certain Medical Supplies
- Enteral Nutrition Products

The transition will not apply to PACE, Cal MediConnect, or SCAN. As of January 1, 2022, any pharmacy claims for members enrolled in the PACE, Cal MediConnect Plans, and SCAN plans billed to the Medi-Cal Rx plan will deny with Reject Code AF – Patient Enrolled Under Managed Care with supplemental message *"Please resubmit to PACE/Cal MediConnect/SCAN XXX Plan."*

8.2.7 Retroactive Eligibility

Some Medi-Cal Rx members become eligible for Medi-Cal Rx after the month in which services were rendered. When submitting claims for Medi-Cal Rx members who have retroactive eligibility and additional information is required, a paper claim form will be required in the same manner as for other late billings. Refer to [Section 19.3.1 – Submission and Timeliness Instructions](#), and the *Billing Limit Exceptions* table within that section for more information.

The provider has 60 days from the date of receipt of retroactive eligibility information to bill Medi-Cal Rx. Proof of eligibility must be received within one year from the month service was rendered. For information on identifying member eligibility, including retroactive eligibility, refer to [Section 8.0 – Member Eligibility](#).

8.2.8 Eligibility Service Restrictions

Under federal and state law, Medi-Cal may place a member on restricted eligibility status. Members who meet the criteria may have utilization restrictions. Medi-Cal Rx will return an error message notifying the provider of the restricted services and a PA is required.

Prescription Drugs

DHCS may restrict access to prescription drugs for members and may be subjected to one or more forms of utilization restrictions.

These members receive a regular BIC, but when verifying eligibility, the Medi-Cal eligibility verification system will deny the claim with Reject Code 75 – Prior Authorization Required and supplemental message *"Recipient has restricted services. Prior Authorization required for drugs."* This restriction requires an approved PA for all nonemergency prescription drugs. California law stipulates that prescriptions and emergency room visits do not apply to a restricted member in any instance where a bona fide emergency exists which requires immediate treatment.

This restriction requires an approved PA for all nonemergency prescription drugs. Retroactive paper ID cards for members with this restriction will have the code "P/A ALL RX."

Scheduled Drugs

DHCS may also restrict access to certain scheduled drugs. These members receive a regular BIC, but when verifying eligibility, the Medi-Cal Rx eligibility verification system will deny the claim with Reject Code 75 – Prior Authorization Required and supplemental message *“Recipient has restricted services. Prior Authorization required for scheduled drugs.”* This restriction requires an approved PA for all nonemergency prescription drugs. Retroactive paper ID cards for members with this restriction will have the code “P/A SCHR.X.”

Note: Authorization is not required for nonscheduled drugs contained in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#) and then **Covered Products Lists**).

9.0 Member Financial Responsibilities

9.1 Copays

Table 9.1-1 below shows the standard copay for members.

Standard Copay	
Generic	\$0.00
Brand	\$0.00

Table 9.1-1: Standard Copays

9.2 Deductibles

Table 9.2-1 below shows the standard deductible for members.

Description	Standard	Comments
Deductible		N/A

Table 9.2-1: Standard Deductible

9.3 Share of Cost (SOC)

Some Medi-Cal members must pay, or agree to pay, a monthly dollar amount toward their medical expenses before they qualify for Medi-Cal Rx benefits. This dollar amount is called Share of Cost (SOC). A Medi-Cal SOC is similar to a private insurance plan’s Out-Of-Pocket (OOP) deductible or can sometimes be referred to as a Spend Down.

The SOC can and may change month to month. DHCS will track when SOC has been met. Refer to Table 9.3-1.

Until the member has met the SOC, the claim will be denied for unmet SOC (Reject Code AA – Patient spenddown not met) with supplemental messaging advising of remaining SOC. However, once the member meets the SOC, the claim will then proceed to be processed per Medi-Cal Rx claim edits and audits. Pharmacy providers with questions regarding SOC, can call

the Automated Eligibility Verification System (AEVS) at 1-800-456-AEVS (2387) or the Medi-Cal Telephone Service Center (TSC) at 1-800-541-5555.

Note: The TSC is *different* than the Medi-Cal Rx CSC.

For information on SOC and mechanisms on how to report spend-down, refer to the applicable links on SOC and on the Automated Eligibility Verification System (AEVS) in the [DHCS Provider Manual \(Part 1\)](#).

Note: Beginning January 1, 2022, Box 28 and Box 29 (Patient's Share) on the *California Specific Pharmacy Claim Form (30-1)* and *California Specific Compound Pharmacy Claim Form (30-4)*, is **not** required and should be LEFT BLANK.

Description	Standard/Frequency	Comments
Share of Cost	Monthly	

Table 9.3-1: Share of Cost Frequency

9.4 Out-of-Pocket Maximum

Table 9.4-1 below shows the standard out-of-pocket maximum for members.

Description	Standard	Comments
Benefit maximum		N/A

Table 9.4-1: Out-of-Pocket Maximum

9.5 Patient Paid Amount

Table 9.5-1 below shows information regarding the Patient Paid Amount field.

Patient Paid Amount		
Patient Paid Amount field	If greater than \$0.00, reject the claim if provider submitted claim.	Reject Code DX – M/I patient paid amount submitted with the supplemental message "Patient Paid Amount Must = Zero" if provider submitted.

Table 9.5-1: Patient Paid Amount

10.0 Coordination of Benefits (COB)

COB is the mechanism used to designate the order in which multiple plans or carriers are responsible for benefit payments and prevention of duplicate payments.

The plan or carrier can be:

- An individual
- A group
- Employer-related
- Self-insured
- A self-funded plan

The term “Other Health Coverage” (OHC) is used to describe any source other than Medicaid that has a financial obligation for health care coverage.

OHC refers to:

- An insurance plan or carrier
- A program
 - **Note:** The program can be Medicare, which has liability for all or part of a beneficiary’s medical or pharmacy coverage.
- A commercial carrier

Not Considered to be OHC

The following is a partial list of insurance that is not considered to be OHC:

- Personal injury and/or medical payment coverage covered under automobile insurance
- Life insurance
- Workers’ Compensation
- Homeowners insurance
- Umbrella insurance
- Accident insurance
- Income replacement insurance (for example, AFLAC®)

Payer of Last Resort Exceptions

Medi-Cal Rx is the payer of last resort, except in the following situations:

- Member also has AIDS Drug Assistance Program (ADAP), Indian Health Services, or Veteran's Administration (VA) Services.
- Beneficiary has Medicare Part D and the product is not excluded by Medicare Part D Law.

If a member has coverage through one of these programs, Medi-Cal Rx is not considered a payer.

10.1 COB General Instructions

Members are required to utilize their OHC prior to Medi-Cal Rx when the same service is available under the member's OHC. If the member chooses to pursue services not covered by their OHC, Medi-Cal Rx will not assume liability for the cost of those services and claims will be denied.

Notes:

- Online COB (for example, cost-avoidance) is performed. COB edits will be applied when OHC exists for the member and claim DOS. If a claim does not contain COB information for a member who has active OHC on file, the claim will deny with Reject Code 41 – Submit Bill to Other Processor or Primary Payer.
- COB claims may need to be submitted to Medi-Cal Rx using other coverage codes (OCCs) to identify if other coverage exists and if payment was collected from the primary payer, when applicable. Refer to the table in [Section 10.5 – Allowed OCC for Standard OHC and Medicare Part B and Part D](#) for allowed OCCs for standard OHC and Medicare Part B and Part D.

If the Medi-Cal Rx eligibility verification system(s) indicates that a member has OHC, but the member claims there is no OHC, advise the member to contact the county eligibility worker. Upon receiving consent from the member, providers, including pharmacies, may also assist with submitting requests to update a member's OHC status. Additional information for providers can be found on the [Other Health Coverage](#) page on the DHCS website.

10.2 Pharmacy Self-Certification for OHC

Pharmacy providers may complete self-certification for OHC electronically or by using the UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4). Pharmacy providers do not need to submit an OHC attachment. However, pharmacy providers must be able to readily retrieve proof of claim submission and payment if collected from other payer(s).

Electronic Self-Certification

Electronic/online COB (for example, cost-avoidance) is performed when submitting claims via POS or WCS. COB edits will be applied when OHC exists for the member on the claim DOS. If a claim is submitted to Medi-Cal Rx and does not contain COB information for a member who has active OHC on file, the claim will deny with Reject Code 41 – Submit Bill to Other Processor or Primary Payer. Refer to [Section 10.5 – Allowed OCC for Standard OHC and Medicare Part B and Part D](#).

Claim Form Self-Certification

OHC will be self-certified for providers submitting paper claims if the Other Payer Amount Paid #1/#2 field(s) (Field 84/85 (UCF)), Other Coverage Paid field (Box 26 (30-1) or Box 27 (30-4)) and the Other Coverage (Field 45 (UCF)), or Other Coverage Code field (Box 27 (30-1) or Box 28 (30-4)) are completed as instructed in [Section 19.1.1 – Completion Instructions for the UCF](#).

[Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#), or [Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#).

10.3 Identifying OHC

OHC can be identified using the POS system, the Member Eligibility Lookup Tool on the [Medi-Cal Rx Secured Provider Portal](#), or Medi-Cal's AEVS (refer to [Section 3.5 – Automated Eligibility Verification System \(AEVS\)](#)).

10.3.1 Identifying Member's OHC via POS Claims

If a member has other coverage on a DOS and it is not reported on the pharmacy's claim submission, Medi-Cal Rx will deny the claim in the POS system with Reject Code 41 – Submit Bill to Other Processor or Primary Payer and return the Other Payer details of the active OHC on file in the "COB Response Segment" if available:

- Other Payer Coverage Type
- Other Payer ID Qualifier
- Other Payer ID
- Other Payer Processor Control Number (PCN)
- Other Payer Cardholder ID
- Other Payer Group ID
- Other Payer Person Code
- Other Payer Help Desk Phone Number
- Other Payer Patient Relationship Code
- Other Payer Benefit Effective Date
- Other Payer Benefit Termination Date

Items returned are subject to information received on the member's COB records.

Note: Reimbursement will be calculated to pay the lesser of the Medi-Cal Rx allowed amount minus the third-party payment.

10.3.2 Identifying Member's OHC via Member Eligibility Lookup Tool

The Member Eligibility Lookup Tool is available to registered providers on the [Medi-Cal Rx Secured Provider Portal](#) (refer to [Section 3.6.1.2 – Secured Provider Portal](#)). Once a provider has successfully logged in, they can select **Member Eligibility Lookup Tool** from the Tools & Resources drop-down menu. When the required member information has been entered (Last Name, Birth Date, Service Date, and either Member ID/Client Index Number or First Name/Gender), providers will select **Search**. Upon finding a successful match, the member information along with their eligibility and claims history will be displayed, including OHC. Refer to [Appendix G – OHC Carrier Information](#) for Medi-Cal OHC Carrier information pertaining to drug-related coverage. The table includes information on Other Payer IDs, Other Payer Names, and corresponding phone numbers. Refer to *Figure 10.3.2-1*.

Member Eligibility Lookup

Member eligibility data for Medi-Cal Rx Pharmacy Prior Authorizations and Claims only.
Search results as of 4/30/2024, 3:05:43 PM (PT)

[< Back to search](#)

Demographics & Eligibility Details

Name:	Janet Smith	Service Date:	04/30/2024
Date of Birth:	06/03/2003	Medicare Part B Coverage:	No
Status:	Eligible	Medicare Part D Coverage:	No
Gender:	Female	Other Health Coverage:	
Member ID Number:	3456789 IE	Share of Cost:	
Internal Code:	Real-Time		

Medi-Cal Eligibility Aid Code(s)

Aid Code Type	Aid Code	Program/Description	Rx Benefit	Level Benefits
Primary Aid Code	M1	Adults - Ages 19 to 64 - Modified Adjusted Gross Income (MAGI) 0% to 138% Federal Poverty Level (FPL)	Yes	Full Scope (No SOC)

CCS, GHPP, FPACT Eligibility Aid Code(s)

HAP Status	Aid Code	Program/Description	Rx Benefit	County
Active	9K	California Childrens Services (CCS)	Yes	Ventura

Eligibility History

Effective Date	Termination Date
01/01/2024	01/01/3000
02/01/2020	12/31/2023

Claims History

Figure 10.3.2-1: Member Eligibility Lookup Tool

10.4 Medicare

Some Medi-Cal members are also eligible for services under the federal Medicare program. For most services rendered, Medicare Part B requires a deductible and/or coinsurance, which may be paid by Medi-Cal Rx in certain cases.

Note: Medicare Part D deductibles and/or coinsurance are not paid for by Medi-Cal Rx.

10.4.1 Medicare Part B COB Claims

Medi-Cal Rx will allow a COB claim via POS when it is submitted with an Other Payer ID of "444444" and Other Payer ID Qualifier of "99 – Other" to identify that Medicare Part B was billed as the primary payer. Medi-Cal Rx also supports paper claims to ensure that Medicare is responsible for their portion of claim payment. For Medicare/Medi-Cal Rx crossover claims for Medicare-approved services that are not able to be billed at POS, the UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4) paper claim forms can be utilized (refer to [Section 19.1 – Universal Claim Form, Version D.0](#), [Section 19.2.1 – California Specific Pharmacy Claim Form \(30-1\)](#), and [Section 19.2.2 – California Specific Compound Pharmacy Claim Form \(30-4\)](#)). Providers must submit crossover claims to Medi-Cal Rx (refer to [Appendix B – Directory](#) for mailing addresses).

Claim Submission for Members with Medicare Part B Coverage

- If the claim is submitted to Medi-Cal Rx directly for a Medicare Part B-covered service, the claim will deny with Reject Code A6 – Product/Service May Be Covered Under Medicare Part B with the supplemental message "Bill Medicare." The claim must be resubmitted as a COB claim.

- If the claim is submitted as a COB claim to Medicare Part B and then to Medi-Cal Rx for a Medicare Part B-covered service, with the applicable OCC, the claim will process and pay accordingly.
 - If the Medicare Part B payer accepts the claim and the dollar amount collected is greater than \$0.00, the claim should be submitted with OCC equals 2 – Other Coverage Exists Payment Collected.
 - If the Medicare Part B payer accepts the claim and the dollar amount collected equals \$0.00, the claim should be submitted with OCC equals 4 – Other Coverage Exists Payment Not Collected.
- If the claim is submitted as a COB claim to Medicare Part B and then to Medi-Cal Rx where Medicare Part B did not accept the claim, the claim will deny with Reject Code 13 – M/I Other Coverage Code.

Note: If the claim does not cross over automatically to the MCP or FFS Medi-Cal, the pharmacy must submit the claim for the deductible and/or coinsurance for a Medicare Part B eligible drug to Medi-Cal Rx using the specific Medicare Part B Other Payer ID ("444444"), the Other Payer ID Qualifier ("99 – Other"), the applicable OCC, and the dollar amount collected. Refer to the table in [Section 10.5 – Allowed OCC for Standard OHC and Medicare Part B and Part D](#) and the [Medi-Cal Rx Billing Tips](#) for additional information.

Reimbursement

Medi-Cal Rx reimbursement is based on the Medi-Cal Rx allowable amount, minus any payment a pharmacy provider has received from Medicare and/or from private insurance and member SOC. California law limits Medi-Cal's reimbursement for a crossover claim to an amount that, when combined with the Medicare payment, should not exceed Medi-Cal Rx's maximum allowed for similar services (refer to W&I Code, Section 14109.5).

Note: Medicare Part B deductibles and/or coinsurance, in some instances, are paid for by Medi-Cal Rx.

PA Request

- COB claims accepted by Medicare Part B and submitted to Medi-Cal Rx for drugs/products not excluded from Medi-Cal Rx coverage are not subject to Medi-Cal Rx utilization management (UM) claim edits and will not require a PA request submission for coverage considerations.
- COB claims accepted by Medicare Part B and submitted to Medi-Cal Rx for products excluded from Medi-Cal Rx coverage are subject to Medi-Cal Rx UM claim edits and will require a PA request for coverage considerations. Claims will only be eligible for reimbursement with an approved PA request.

Note: In the event a claim is billed to Medicare Part B and Medicare Part B denies the claim for coverage determination, a PA request must be submitted to Medicare for coverage.

10.4.2 Charpentier Claims

A permanent injunction (*Charpentier v. Belshé [Coye/Kizer]*) filed December 29, 1994, allows providers to rebill Medi-Cal Rx for supplemental payment for Medicare/Medi-Cal Part B services, excluding physician and laboratory services. This supplemental payment applies to Medi-Cal FFS crossover claims when Medi-Cal Rx's allowed rates or quantity limitations exceed the Medicare allowed amount. This applies only to Part B services billed to Part B carriers. All Charpentier rebills for pharmacy claims **must** be submitted via a paper claim form. The following definitions apply to Charpentier rebills (refer to [Section 19.3.3 – Tips for Billing Charpentier Claims](#) for how and where to utilize the following indicators):

- Rates (R) – The Medi-Cal Rx allowed amount for the item or service exceeds the Medicare allowed amount.
- Benefit Limitation (L) – The quantity of the item or service is cut back by Medicare due to a benefit limitation.
- Both Rates and Benefit Limitation (T) – Both the Medi-Cal Rx allowed amount for the item or service exceeds the Medicare allowed amount and the quantity of the item or service is cut back by Medicare due to a benefit limitation.

All Charpentier rebilled claims must have been first processed as Medicare/Medi-Cal crossover claims.

Medicare Allowed Amount

If there is no price on file, Medi-Cal Rx adopts the Medicare allowed amount and a cutback is *not* reflected on the RA.

Exceeds Medicare's Allowed Amount

If Medi-Cal Rx's rates and/or limitations are greater than that of Medicare, rebill the claim by following Charpentier billing instructions and attaching appropriate pricing documentation.

Note: Do not use a CIF to rebill a Charpentier claim.

Where to Submit Charpentier Rebills

All Charpentier rebills for pharmacy claims **must be submitted via a paper claim form** (refer to [Section 19.0 – Claim Forms](#) and [Section 19.3.3 – Tips for Billing Charpentier Claims](#) for additional information) and mailed to the Medi-Cal Rx vendor (refer to [Appendix B – Directory](#) for mailing address).

Submission Requirements

Providers must use the following submission requirements to be considered for supplemental payment under the Charpentier injunction:

- Providers must first bill Medicare and any OHC to which the member is entitled.

- The claim must then be billed as a crossover and approved by Medi-Cal Rx. This can happen one of two ways:
 - The claim may cross over automatically from the Part B carrier (via POS/electronic submission).
 - The crossover claim may be hard copy billed (paper claim) to Medi-Cal by the provider.

Additional Billing Tips for Charpentier Claims

- A Charpentier rebill must not be combined with a crossover claim.
- Use of Charpentier indicators ("R," "L," or "T") on claims that are not Charpentier claims will result in processing delays.
- Failure to place a Charpentier indicator ("R," "L," or "T") on a legitimate Charpentier claim prevents the system from recognizing the claim as a Charpentier rebill which may result in processing delays or denial of the claim.
- Claims with incorrectly marked MRN will be denied.
- Providers must obtain an approved PA request if a PA request would be required when billed as a Medi-Cal Rx only claim.

Providers are not required to submit a copy of the Medicare Appeal and Decision form when billing Medi-Cal Rx for the difference between Medicare and Medi-Cal.

10.4.3 Medicare Part D COB

Medi-Cal Rx will adjudicate claims for products excluded from Medicare Part D coverage by law for members that have Medicare Part D. Medi-Cal Rx will not reimburse Medicare Part D deductibles or copayments.

Claim Submission for Members with Medicare Part D Coverage

- If the claim is submitted directly to Medi-Cal Rx for a Medicare Part D covered product, the claim will deny with Reject Code 620 – This Prod/Service may be covered under Medicare Part D.
- If the claim is for a Medicare Part D excluded product, the claim can be submitted directly to Medi-Cal Rx without COB information. Medi-Cal Rx UM claim edits will apply, and PA request submission may be required for coverage considerations.
- If the claim is submitted as a COB claim to Medicare Part D and then to Medi-Cal Rx with OCC equals 2 – Other Coverage Exists Payment Collected or OCC equals 4 – Other Coverage Exists Payment Not Collected for a Medicare Part D covered product, the claim will deny with Reject Code 13 – M/I Other Coverage Code with the supplemental message *"Medicare Part D copays and deductibles are not covered."*
- If the claim is submitted as a COB claim to Medicare Part D and then to Medi-Cal Rx with OCC equals 3 – Other Coverage Exists Claim Not Covered for a product not excluded by Medicare Part D Law, the claim will deny with Reject Code 6E – M/I Other Payer with the supplemental message *"Other Payer Reject Code not allowed."* The claim should be submitted to Medicare Part D. Medi-Cal Rx is not considered a payer in this situation.

Note: In the event a claim is billed to Medicare Part D and Medicare Part D denies the claim with Reject Code A5 – Not Covered Under Part D Law or Reject Code 65 – Patient is Not Covered, the claim can be submitted to Medi-Cal Rx as a COB claim using OCC equals 3 – Other Coverage Exists Claim Not Covered. Refer to the table in [Section 10.5 – Allowed OCC for Standard OHC and Medicare Part B and Part D](#) and the [Medi-Cal Rx Billing Tips](#) for additional information.

PA Request

Claims submitted to Medi-Cal Rx in the following situations are subject to Medi-Cal Rx UM claim edits, and PA request submission may be required for coverage considerations:

- Claims submitted for drugs/products excluded from Medicare Part D coverage.
- Claims submitted for drugs/products with OCC equals 3 in which Medicare Part D denies the claim with Reject Code A5 or Reject Code 65.

Note: In the event a claim is billed to Medicare Part D and Medicare Part D denies the claim for coverage determination, a PA request must be submitted to Medicare Part D for coverage. Coverage questions regarding denied claims or a denied PA should be directed to the beneficiary's Medicare plan.

10.5 Allowed OCC for Standard OHC and Medicare Part B and Part D

Refer to *Table 10.5-1* for the allowed OCC for standard OHC and Medicare Part B and Part D and the [Medi-Cal Rx Billing Tips](#) for additional information.

OCC	Description	Allowed for Standard OHC Processing	Allowed for Medicare Part B Processing	Allowed for Medicare Part D Processing
0	Not Specified	Yes – If no OHC is on file. If OHC is on file, claims will deny.	Yes – If no Part B is on file. If Part B is on file, claims will deny.	Yes – If no Part D is on file. If Part D is on file, claims will deny. Note: If the drug is excluded from Medicare Part D, then this OCC value is allowed.

OCC	Description	Allowed for Standard OHC Processing	Allowed for Medicare Part B Processing	Allowed for Medicare Part D Processing
1	No Other Coverage Exists	Yes – If no OHC is on file. If OHC is on file, claims will deny.	Yes – If no Part B is on file. If Part B is on file, claims will deny.	Yes – If no Part D is on file. If Part D is on file, claims will deny. Note: If the drug is excluded from Medicare Part D, then this OCC value is allowed.
2	Other Coverage Exists Payment Collected	Yes – If OHC is on file and payer amount is greater than \$0.00.	Yes – If COB indicates the primary payer is Part B and payer amount is greater than \$0.00.	No – If COB indicates the primary payer is Part D. Note: If the drug is excluded from Medicare Part D, then this OCC value is allowed.
3	Other Coverage Exists Claim Not Covered	Yes – Must be one of the reject codes that are in the table in Section 10.5.1 – OCC Equals 3 Reject Codes .	No – Claims will deny.	Yes – Only when Part D denies with Reject Code 65 – Patient is Not Covered or with Reject Code A5 – Not Covered Under Part D Law. Note: If the drug is excluded from Medicare Part D, then this OCC value is allowed.
4	Other Coverage Exists Payment Not Collected	Yes – If OHC is on file and payer amount is equal to \$0.00.	Yes – If COB indicates the primary payer is Part B and payer amount is equal to \$0.00.	No – If COB indicates the primary payer is Part D. Note: If the drug is excluded from Medicare Part D, then this OCC value is allowed.

Table 10.5-1: Allowed OCC for Standard OHC and Medicare Part B and Part D

Note: Pharmacy claims will pay at \$0.00 and therefore will not send a negative amount in the **Amount Paid** field if the OHC payment and copayment are greater than Medi-Cal Rx's allowable amount.

10.5.1 OCC Equals 3 Reject Codes

Refer to *Table 10.5.1-1* for the OCC equals 3 reject codes and descriptions.

Reject Code	Reject Code Description
52	Non-Matched Cardholder ID
63	Institutionalized Patient Product/Service Not Covered
65	Patient is Not Covered
66	Patient Age Exceeds Maximum Age
67	Filled Before Coverage Effective
68	Filled After Coverage Expired
69	Filled After Coverage Terminated
70	Product/Service Not Covered
7Y	Compounds Not Covered
9G	Quantity Dispensed Exceeds Maximum Allowed
9Q	Route of Administration Submitted Not Covered
M1	Patient Not Covered in this Aid Category
N1	No Patient Match Found
A5	Not Covered Under Part D Law
MR	Product Not on Formulary
AA	Patient Spenddown Not Met

Table 10.5.1-1: OCC Equals 3 Reject Code Descriptions

Medi-Cal Rx will deny COB claims with Reject Code 6E – M/I Other Payer Reject Code with the supplemental message “*Other Payer Reject Code Not Allowed*” in the following situations:

- **Standard OHC:** When OCC equals 3 – Other Coverage Found Claim Not Covered is used indicating the Other Payer denied the claim and the Other Payer reject code is not found in *Table 10.5.1-1*.
- **Medicare Part D:** When OCC equals 3 – Other Coverage Found Claim Not Covered is used indicating the Other Payer denied the claim and the Other Payer Reject Code is not Reject Code 65 – Patient is Not Covered or Reject Code A5 – Not Covered Under Part D Law.

Note: For pharmacy providers submitting paper claims (UCF, (30-1), or (30-4)), the OCC equals 3 reject codes will be visible on the Medi-Cal Rx Provider Portal, via the POS system.

11.0 Contract Drugs List (CDL)

Drugs listed on the *Medi-Cal Rx Contract Drugs List* (CDL) generally include products for which there have been ongoing or past supplemental rebate agreements in place.

The following is available on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**:

- [Medi-Cal Rx Contract Drugs List](#) (CDL) – A searchable document containing the complete CDL, which is categorized by drug class and contains dose and strength information, along with coverage restrictions.

11.1 Code I Restrictions

Certain medications are restricted to specific members based on criteria such as age, quantity, drug therapy, drug duration, and diagnosis. Code I Limitations will be identified in the CDL and marked with an asterisk (*).

Code I drugs require authorization in accordance with Section 51003 unless used under the conditions specified in the CDL (found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**) and are subject to the prescription documentation requirements in CCR, Title 22, Section 51476(c). Refer to CCR, Title 22, Section 51313.3(b). The Code I requirements must be met in order to receive the medication(s) (refer to the [CDL](#)) without a PA request. If the Code I requirements are not met, pharmacies will only be reimbursed by Medi-Cal Rx with an approved PA request.

Note: For Code I restrictions, such as age, quantity, duration, or labeler-restricted products, Medi-Cal claim edits will manage compliance. The submitter will receive an appropriate reject code for situations of noncompliance. Alternatively, for Code I restricted products with a diagnosis/type of illness restriction, the submitter may communicate the restriction has been met using a submission clarification code (SCC) value of 7 – Medically Necessary. For additional information regarding applicable NCPDP fields, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Refer to [Section 14.0 – Prior Authorization Request Overview, Request Methods, and Adjudication](#) for information on the methods available to submit/request a PA.

11.2 Limitations on Coverage of Certain Drugs or Classes of Drugs

In compliance with state and federal Centers for Medicare & Medicaid Services (CMS) requirements, pharmacy providers and prescribers are reminded certain drugs or classes of drugs, or their medical uses, are excluded from coverage or otherwise restricted under Medi-Cal Rx pharmacy benefits.

11.2.1 List of Drugs Subject to Restriction

FDA-approved drug products are excluded from coverage or otherwise restricted under Medi-Cal Rx Pharmacy Benefit where the FDA indication is **solely**:

- For anorexia, weight loss, or weight gain.
- To promote fertility.
- For cosmetic purposes or hair growth.
- For the treatment of sexual or erectile dysfunction.

11.2.2 Exceptions to Drugs Subject to Restriction

A pharmacy provider or prescriber may submit a PA request for an unlabeled use or a medically accepted use of a restricted FDA approved product for a member when medically necessary. Unlabeled use of drugs means the use of an already marketed drug for a clinical indication not listed in the approved labeling of the drug by the FDA.

12.0 Enteral Nutrition Products

Enteral nutrition products are eligible for coverage via Medi-Cal Rx if all of the following requirements are met:

- Product is for outpatient use.
- Product is a contracted enteral nutrition product.
- Product is prescribed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant (refer to [Section 12.3 – Prescription Requirements](#)).
- Product requests meet the established requirements (refer to [Section 12.5 – Authorization](#)).

All enteral nutrition products require prior authorization (PA) and are used as a *"therapeutic regimen to prevent serious disability or death in patients with medically diagnosed conditions that preclude the full use of regular food"* (W&I Code, Sections 14105.395, 14105.8, and 14132.86). Contracted enteral nutrition products are subject to the [List of Contracted Enteral Nutrition Products](#). To review the *List*, navigate to the [Medi-Cal Rx Web Portal](#) and select

Contract Drugs & Covered Products Lists from the Tools & Resources drop-down menu.

Certain products (specific Medi-Cal 11-digit NDCs) have additional requirements that must be met, which can be found in the product-specific criteria column within the published [List of Contracted Enteral Nutrition Products](#).

Enteral nutrition products are not separately reimbursable to inpatients receiving inpatient hospital services, Nursing Facility Level A or Level B services, inpatients in an Intermediate Care Facility for the Developmentally Disabled (ICF/DD), Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H), or Intermediate Care Facility for the Developmentally Disabled/Nursing (ICF/DD-N). Enteral nutrition products are reimbursed as part of the facility's reimbursement or daily rate (CCR, Title 22, Sections 51510.1, 51510.2, and 51510.3).

DHCS shall recover overpayments for noncovered services, which include 100 percent of the ingredient cost and professional fee pursuant to CCR, Title 22, Section 51488.1(a)(2).

12.1 Noncovered Nutrition Products

The following nutrition products are **not** covered by Medi-Cal Rx:

- Regular food, including solid, semi-solid, blenderized, and pureed foods.
- Common household items and remedies such as medical foods, enteral nutritional supplements, or replacements except for items included in the [List of Contracted Enteral Nutrition Products](#).
- Regular infant formula as defined in the Federal Food, Drug and Cosmetic Act (FD&C Act).
- Shakes, cereals, thickened products, puddings, bars, gels, and other non-liquid products.
- Thickeners.
- Products for assistance with weight loss.
- Enteral nutrition products used orally as a convenient alternative to preparing and/or consuming regular, solid, or pureed foods.

12.2 Covered Products

Enteral nutrition products covered via Medi-Cal Rx can be found in the [List of Contracted Enteral Nutrition Products](#). The products are categorized as follows:

- **Standard:** Contain intact macronutrients and be nutritionally complete and a sole source of nutrition where no additional elements, vitamins, minerals, nor macronutrients are additionally required.
- **Specialized:** Disease-specific with intact macronutrients and modulars.
- **Elemental** and **Semi-elemental:** Nutritionally complete formula which contains Extensively Hydrolyzed Products (EH) (peptide) or fully broken-down (amino acid) protein macronutrients.
- **Metabolic:** Indicated for inborn errors of metabolism diagnoses for infant, pediatric, and adult Medi-Cal members.
- **Specialty Infant:** Indicated for specific diagnosis or conditions for individuals 1 year of age and younger.

Note: Contracted products may have additional product category and product specific requirements that must be addressed with the PA request submission.

12.3 Prescription Requirements

The California State Plan (3.1-A, 7c.3) states that enteral nutrition products are covered only when supplied by a pharmacy provider upon the prescription of a prescriber within the scope of their practice. A written or electronic prescription signed by a physician, nurse practitioner, clinical nurse specialist, or physician assistant is required for authorization of all enteral nutrition products. The prescriber's full name, address, and telephone number must be clearly supplied if not preprinted on the prescription form.

12.4 Documentation Requirements

All of the following clinical and product information, as documented in the member's medical record, must be clearly supplied on the PA request or as an attachment within the PA request. Required information includes the following:

- Medical diagnosis code related to the product requested.
 - *International Classification of Diseases – 10th Revision, Clinical Modification* (ICD-10-CM) codes are required for certain product category types and/or diagnoses. Refer to the following sections for each product category for additional information about ICD-10-CM code requirements.
 - **Note:** If the ICD-10-CM code is not listed in the following product-specific sections, but the prescriber has determined the Medi-Cal member meets the product-specific requirements, documentation should be included supporting the request of the non-listed ICD-10-CM code.
- Daily caloric requirements of the requested enteral nutrition product.
 - This information (along with other medical measurements and labs) must be dated within 365 days (12 months) of the request, with the exception of specialty infant products, which must be dated within 120 days (4 months) of the request.
- Indication if the member is tube fed or orally fed.
- 11-digit product NDC.
- Optional: height (length) and weight.
 - If provided, height (length) and weight may assist with the evaluation of quantities requested that exceed the maximum daily caloric limits.

Note: Providers are encouraged to use the [Medi-Cal Rx Enteral Nutrition Prior Authorization Request](#) form when submitting requests via fax or U.S. mail.

12.5 Authorization

All enteral nutrition products require an authorization and are eligible for coverage consideration if the following requirements are met:

- Product is dispensed for outpatient use by a pharmacy provider.
- Product prescribed is on the established [List of Contracted Enteral Nutrition Products](#).
- PA meets the documentation requirements. Refer to [Section 12.4 – Documentation Requirements](#).
 - Medical information (where required) must be dated within 120 days (4 months) of the request for specialty infant products. For all other categories, the medical information (where required) must be dated within 365 days (12 months) of the request.
- Product meets the product category specific requirements.
- Product meets the product specific requirements.

- Medical necessity is established addressing the daily caloric requirements. Daily caloric limits are assessed during the PA request review. The maximum daily caloric limits are based on feeding status, age, and product category/type as follows:
 - **Tube Fed:** Up to 2,000 calories/day for all products except infant products
 - **Orally Fed and 22 years of age and older:** Up to 1,200 calories/day
 - **Orally Fed and 21 years of age and younger:** Up to 1,000 calories/day
 - **Infant Products and younger than 1 year of age:** Up to 800 calories/day regardless of feeding status

Note: Medi-Cal Rx PA requests for enteral nutrition products can be approved for up to 1 year and up to a 31-day supply for each fill, unless noted.

12.5.1 Standard Products

To be considered for authorization of standard products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet **one** of the following diagnoses:

- Severe swallowing or chewing difficulty due to one of the following:
 - Cancer of the mouth, throat, or esophagus
 - Injury, trauma, surgery, or radiation therapy involving the head or neck
 - Chronic neurological disorders
 - Severe craniofacial anomalies
 - Transitioning from parenteral or enteral tube feeding to an oral diet
- Diagnosis listed in the following *Standard Product Type Diagnosis Table*. Refer to *Table 12.5.1-1*.

Standard Product Type Diagnosis Table	
ICD-10-CM Code	Diagnosis
C15.3	Malignant neoplasm of upper third of esophagus
C15.4	Malignant neoplasm of middle third of esophagus
C15.5	Malignant neoplasm of lower third of esophagus
C15.8	Malignant neoplasm of overlapping sites of esophagus
C15.9	Malignant neoplasm of esophagus, unspecified
E43	Unspecified severe protein-calorie malnutrition
E45	Retarded development following protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition
E64.0	Sequelae of protein-calorie malnutrition
K14.4	Atrophy of tongue papillae
K22.0	Achalasia of cardia

Standard Product Type Diagnosis Table	
ICD-10-CM Code	Diagnosis
K31.8	Other specified diseases of stomach and duodenum
K31.84	Gastroparesis
K91.30	Postprocedural intestinal obstruction, unspecified as to partial versus complete
K91.89	Other postprocedural complications and disorders of digestive system
M62	Other disorders of muscle
M62.5	Muscle wasting and atrophy, not elsewhere classified
R13.0	Aphagia
R13.1	Dysphagia
R13.19	Other dysphagia
R63.6	Underweight
R64	Cachexia

Table 12.5.1-1: Standard Product Type Diagnosis Table

12.5.2 Specialized Products

To be considered for authorization of specialized products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet the following product type requirements:

- For diabetic, hepatic, or renal specialized products, the member must meet one of the diagnoses from the Standard Product Type criteria (refer to [Section 12.5.1 – Standard Products](#)) as well as one diagnosis from the *Specialized Products Diagnosis Table*. Refer to *Table 12.5.2-1*.
- For modular products, the member must meet the following requirements:
 - One diagnosis from the Standard Product Type criteria (refer to [Section 12.5.1 – Standard Products](#)).
 - Clinical justification for why additional supplementation is required if the member is taking other enteral nutrition supplementation.
 - For modular lipid (fat) products:
 - Clinical documentation that supports a fat malabsorption diagnosis from the *Specialized Products Diagnosis Table* (refer to *Table 12.5.2-1*); **OR**
 - Indication for why the member requires a ketogenic diet for the control of a chronic condition where other enteral nutrition formulas do not meet the member's needs.
 - For modular carbohydrate or protein products:

- Clinical documentation that supports a pulmonary diagnosis from the *Specialized Products Diagnosis Table* (refer to *Table 12.5.2-1*); **OR**
 - A diagnosis and clinical justification that indicates the need for modified macronutrients with additional caloric intake or macronutrient intake.
- **Note:** For modular products, a diagnosis of weight management is excluded.

Specialized Products Diagnosis Table		
Product Type	ICD-10-CM Code	Diagnosis
Specialized, Diabetic	E08	Diabetes mellitus due to underlying condition
	E09	Drug or chemical induced DM
	E10	Type 1 diabetes mellitus
	E11	Type 2 diabetes mellitus
	E13	Other specified diabetes mellitus
	E89.1	Postprocedural hypoinsulinemia
	O24	Diabetes mellitus in pregnancy, childbirth, and puerperium
	R73.9	Hyperglycemia, unspecified
Specialized, Hepatic	B15	Acute hepatitis A
	B17	Other acute viral hepatitis
	E80	Disorders of porphyrin and bilirubin metabolism
	K70	Alcoholic liver disease
	K71	Toxic liver disease
	K72	Hepatic failure, not elsewhere classified
	K74	Fibrosis and cirrhosis of liver
	K76	Other diseases of liver
	K83	Other diseases of biliary tract
	K91	Intraoperative and postprocedural complications and disorders of digestive system, not elsewhere classified
	P78	Other perinatal digestive system disorders
	Q26	Congenital malformations of great veins

Specialized Products Diagnosis Table		
Product Type	ICD-10-CM Code	Diagnosis
Specialized, Renal	N18	Chronic kidney disease
	I12	Hypertensive chronic kidney disease
	I13	Hypertensive heart and chronic kidney disease
	N17	Acute kidney failure
	Z99.2	Dependence on renal dialysis
	N00	Acute nephritic syndrome
Specialized, Modular Lipid	E74.00	Glycogen storage disorder
	E74.810	Glucose transporter 1 deficiency disorder
	E84.0	Cystic fibrosis, with pulmonary manifestations
	E84.1	Cystic fibrosis, with intestinal manifestations
	E84.8	Cystic fibrosis, with other manifestations
	E84.9	Cystic fibrosis, unspecified
	E88.40	Mitochondrial metabolism disorder, unspecified
	E88.41	MELAS syndrome
	E88.42	MERRF syndrome
	G40.909	Seizure disorder
	G40.919	Epilepsy, unspecified, intractable, without status epilepticus
Specialized, Modular Carbohydrate or Protein	E84	Cystic fibrosis
	J41	Simple and mucopurulent chronic bronchitis
	J42	Unspecified chronic bronchitis
	J43	Emphysema
	J44	Other chronic obstructive pulmonary disease
	J95	Intraoperative and postprocedural complications and disorders of respiratory system, not elsewhere classified
	J96	Respiratory failure, not elsewhere classified

Table 12.5.2-1: Specialized Products Diagnosis Table

12.5.3 Elemental and Semi-Elemental Products Criteria

To be considered for authorization of elemental or semi-elemental products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet the following requirements:

- Have an intestinal malabsorption diagnosis (ICD-10-CM Codes K90.0 – K90.9 and K91.2). The diagnosis name and ICD-10-CM code must be clearly supplied on the authorization request.
 - **Note:** Lactose intolerance alone is excluded unless documentation is included that supports a cow's milk protein allergy (CMPA).
- Documentation that the contracted standard or specialized enteral nutrition product has been tried and considered but did not provide adequate nutrition, unless such products are medically contraindicated.

12.5.4 Metabolic Products Criteria

To be considered for authorization of metabolic products on the [List of Contracted Enteral Nutrition Products](#), the member must meet the following product type requirements:

- For ketogenic metabolic products:
 - One of the following diagnoses:
 - Diagnosis from the *Metabolic Products Diagnosis Table* (refer to *Table 12.5.4-1*)
 - Epilepsy and recurrent seizures (ICD-10-CM Code G40)
 - Disorders of plasma protein metabolism (ICD-10-CM Code E88)
 - Documentation that contracted standard or specialized enteral nutrition product has been tried or considered and contracted alternatives are otherwise considered to be clinically inappropriate/inadequate to meet the medical needs of the member.
- For all other metabolic products:
 - One diagnosis from the *Metabolic Products Diagnosis Table*. Refer to *Table 12.5.4-1*.
 - Documentation that contracted standard or specialized enteral nutrition product has been tried or considered and contracted alternatives are otherwise considered to be clinically inappropriate/inadequate to meet the medical needs of the member.

Metabolic Products Diagnosis Table	
ICD-10-CM Code	Diagnosis
E70.0	Classical phenylketonuria
E70.1	Other hyperphenylalaninemias
E70.20 – E70.29	Disorders of tyrosine metabolism
E70.30 – E70.39	Albinism

Metabolic Products Diagnosis Table	
ICD-10-CM Code	Diagnosis
E70.40 – E70.49	Disorders of histidine metabolism
E70.5	Disorders of tryptophan metabolism
E70.8	Other disorders of aromatic amino-acid metabolism
E70.9	Disorder of aromatic amino-acid metabolism, unspecified
E71.0	Maple-syrup urine disease
E71.110 – E71.19	Other disorders of branched-chain amino acid metabolism
E71.2	Disorder of branched-chain amino-acid metabolism, unspecified
E71.30	Disorder of fatty-acid metabolism, unspecified
E71.310 – E71.318	Disorders of fatty-acid oxidation
E71.32	Disorders of ketone metabolism
E71.39	Other disorders of fatty-acid metabolism
E71.40	Disorder of carnitine metabolism, unspecified
E71.42	Carnitine deficiency due to inborn errors of metabolism
E71.50 – E71.548	Peroxisomal disorders
E72.00 – E72.09	Disorders of amino-acid transport
E72.10 – E72.19	Disorders of sulfur-bearing amino-acid metabolism
E72.20 – E72.29	Disorders of urea cycle metabolism
E72.3	Disorders of lysine and hydroxylysine metabolism
E72.4	Disorders of ornithine metabolism
E72.50 – E72.59	Disorders of glycine metabolism
E72.8	Other specified disorders of amino-acid metabolism
E72.9	Disorder of amino-acid metabolism, unspecified
E74.00 – E74.9	Other disorders of carbohydrate metabolism
E75.00 – E75.6	Disorders of sphingolipid metabolism and other lipid storage disorders
E76.01 – E76.9	Disorders of glycosaminoglycan metabolism
E77.0 – E77.9	Disorders of glycoprotein metabolism
E84.0 – E84.9	Cystic fibrosis
E88.40 – E88.49	Mitochondrial metabolism disorders

Table 12.5.4-1: Metabolic Products Diagnosis Table

12.5.5 Specialty Infant Products Criteria

The specialty infant products are grouped in the following product types:

- Premature and Low Birth Weight Products
- Human Milk Fortifier
- Extensively Hydrolyzed Products (EH)
- Amino Acid-Based Products (100 percent)
- Renal Products (Renal)
- Chylolothorax or long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency (LCHAD deficiency) Products

To be considered for authorization of specialty infant products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet the criteria specific to the requested product type listed in *Sections 12.5.5.1 through 12.5.5.6*.

Notes:

- Regular infant formula products as defined in the FD&C Act are not covered.
- For infant metabolic products, refer to the products listed under the metabolic category.
- For products used in fat malabsorption, refer to the amino acid-based products (100 percent).
- Medi-Cal Rx PA requests for specialty infant products can be approved for up to 1 year of age and up to a 31-day supply for each fill, unless noted.

12.5.5.1 Premature and Low Birth Weight Products

To be considered for authorization of premature and low birth weight products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet the following product type requirements:

- One of the diagnoses from the *Premature and Low Birth Weight Diagnosis Table* (refer to *Table 12.5.5.1-1*).
- For products 20 or 22 kcal/ounce:
 - Members born prior to 37 weeks gestation; **OR**
 - Birth weight less than 3,500 grams.
- For products 24 or 30 kcal/ounce, member's current weight (at time of dispensing) is less than 3,500 grams.
 - **Note:** Approvals for these products will be limited to a length of authorization of 1 month only.

Premature and Low Birth Weight Diagnosis Table		
ICD-10-CM Code		Diagnosis
Prematurity ICD-10-CM Codes	P07.21	Extreme immaturity of newborn, gestational age less than 23 completed weeks
	P07.22	Extreme immaturity of newborn, gestational age 23 completed weeks
	P07.23	Extreme immaturity of newborn, gestational age 24 completed weeks
	P07.24	Extreme immaturity of newborn, gestational age 25 completed weeks
	P07.25	Extreme immaturity of newborn, gestational age 26 completed weeks
	P07.26	Extreme immaturity of newborn, gestational age 27 completed weeks
	P07.30	Preterm newborn, unspecified
	P07.31	Preterm newborn, 28 weeks gestation
	P07.32	Preterm newborn, 29 weeks gestation
	P07.33	Preterm newborn, 30 weeks gestation
	P07.34	Preterm newborn, 31 weeks gestation
	P07.35	Preterm newborn, 32 weeks gestation
	P07.36	Preterm newborn, 33 weeks gestation
	P07.37	Preterm newborn, 34 weeks gestation
	P07.38	Preterm newborn, 35 weeks gestation
	P07.39	Preterm newborn, 36 weeks gestation
Low Birth Weight ICD-10-CM Codes	P07.0	Extremely low birth weight newborn, < 999 grams
	P07.00	Extremely low birth weight newborn, unspecified
	P07.01	Extremely low birth weight newborn, < 500 grams
	P07.02	Extremely low birth weight newborn, 500-749 grams
	P07.03	Extremely low birth weight newborn, 750-999 grams
	P07.1	Other low birth weight newborn, 1,000-2,499 grams
	P07.10	Other low birth weight newborn, unspecified weight
	P07.14	Other low birth weight of newborn, 1,000-1,249 grams
	P07.15	Other low birth weight of newborn, 1,250-1,499 grams

Premature and Low Birth Weight Diagnosis Table		
ICD-10-CM Code		Diagnosis
	P07.16	Other low birth weight of newborn, 1,500-1,749 grams
	P07.17	Other low birth weight of newborn, 1,750-1,999 grams
	P07.18	Other low birth weight of newborn, 2,000-2,499 grams
	P05.00	Newborn light for gestational age, unspecified
	P05.10	Newborn small for gestational age, unspecified weight
	P05.11	Newborn small for gestational age, less than 500 grams
	P05.12	Newborn small for gestational age, 500-749 grams
	P05.13	Newborn small for gestational age, 750-999 grams
	P05.14	Newborn small for gestational age, 1,000-1,249 grams
	P05.15	Newborn small for gestational age, 1,250-1,499 grams
	P05.16	Newborn small for gestational age, 1,500-1,749 grams
	P05.17	Newborn small for gestational age, 1,750-1,999 grams
	P05.18	Newborn small for gestational age, 2,000-2,499 grams
	P05.19	Newborn small for gestational age, other

Table 12.5.5.1-1: Premature and Low Birth Weight Diagnosis Table

12.5.5.2 Human Milk Fortifier Products

To be considered for authorization of human milk fortifier products that are on the [List of Contracted Enteral Nutrition Products](#), the member's current weight must be less than 3,600 grams and meet one of the following product type requirements:

- Receiving only human milk and no other infant nutrition product (formula) used at the same time.
- Human fed or receiving human milk in combination with infant nutrition product (formula) administered only through a feeding tube.
- Human fed or receiving human milk in combination with infant nutrition product (formula) administered orally when one of the following conditions is currently documented and met:
 - Infant is at risk for necrotizing enterocolitis.
 - Mother of infant is establishing milk supply.
 - Human milk intake is increasing.

Note: PA approvals for these products will be limited to a length of authorization of 1 month only.

12.5.5.3 Extensively Hydrolyzed Products (EH)

To be considered for authorization of Extensively Hydrolyzed Products (EH) that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet one of the diagnoses from *Table 12.5.5.3-1 – Extensively Hydrolyzed Products (EH) Diagnosis Table*.

Extensively Hydrolyzed Products (EH) Diagnosis Table	
ICD-10-CM Code	Diagnosis
Z91.011	Allergy to milk products (CMPA)
Z91.018	Allergy to other foods (prescriber must indicate soy)
K52.29	Other allergic and dietetic gastroenteritis and colitis
K52.21	Food protein-induced enterocolitis syndrome (FPIES)

Table 12.5.5.3-1: Extensively Hydrolyzed Products (EH) Diagnosis Table

12.5.5.4 Amino Acid-Based (100 Percent) Products

To be considered for authorization of amino acid-based (100 percent) products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet the following product type requirements:

- The member must meet one of the diagnoses from the *Amino Acid-Based (100 Percent) Products Diagnosis Table* (refer to *Table 12.5.5.4-1*).
- Documentation that contracted specialty infant Extensively Hydrolyzed Products (EH) have been tried or considered and contracted alternatives are determined to be clinically inappropriate/inadequate to meet the medical needs of the member or are contraindicated.

Amino Acid-Based (100 Percent) Products Diagnosis Table	
ICD-10-CM Code	Diagnosis
E43	Unspecified severe protein-calorie malnutrition
E44	Moderate protein-calorie malnutrition
E45	Retarded development following protein calorie malnutrition
E46	Unspecified protein-calorie malnutrition
K90.49	Malabsorption due to intolerance, not elsewhere classified
K90.4	Other malabsorption due to intolerance
K90	Intestinal malabsorption
K90.821	Short bowel syndrome, with colon in continuity
K90.822	Short bowel syndrome, without colon in continuity

Amino Acid-Based (100 Percent) Products Diagnosis Table	
ICD-10-CM Code	Diagnosis
K90.829	Short bowel syndrome, unspecified
Z91.011	Allergy to milk products (CMPA)
Z91.018	Allergy to other foods (prescriber must indicate soy)
K52.29	Other allergic and dietetic gastroenteritis and colitis
K52.21	Food protein-induced enterocolitis syndrome
K52.81	Eosinophilic gastritis or gastroenteritis
K52.82	Eosinophilic colitis
K20.0	Eosinophilic esophagitis

Table 12.5.5.4-1: Amino Acid-Based (100 Percent) Products Diagnosis Table

12.5.5.5 Renal Specialty Infant Products

To be considered for authorization of renal specialty infant products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet one of the diagnoses from the *Renal Specialty Infant Products Diagnosis Table*. Refer to *Table 12.5.5.5-1*.

Renal Specialty Infant Products Diagnosis Table	
ICD-10-CM Code	Diagnosis
N17	Acute kidney failure
N18	Chronic kidney disease
P96.0	Congenital renal failure
N00	Acute nephritic syndrome
I12	Hypertensive chronic kidney disease
I13	Hypertensive heart and chronic kidney disease
E83.52	Hypercalcemia
E83.39	Other disorders of phosphorus metabolism

Table 12.5.5.5-1: Renal Specialty Infant Products Diagnosis Table

12.5.5.6 Chyllothorax or LCHAD Deficiency Specialty Infant Products

To be considered for authorization of chyllothorax or LCHAD deficiency specialty infant products that are on the [List of Contracted Enteral Nutrition Products](#), the member must meet one of the diagnoses from the *Chyllothorax or LCHAD Deficiency Specialty Infant Products Diagnosis Table*. Refer to *Table 12.5.5.6-1*.

Chyllothorax or LCHAD Deficiency Specialty Infant Products Diagnosis Table	
ICD-10-CM Code	Diagnosis
J94.0	Chylous effusion
I89.8	Other specified noninfective disorders of lymphatic vessels and lymph nodes
E71.310	Long chain/very long chain acyl CoA dehydrogenase deficiency
E84.0-E84.9	Cystic fibrosis
E88.4	Mitochondrial cystic fibrosis disorder

Table 12.5.5.6-1: Chyllothorax or LCHAD Deficiency Specialty Infant Products Diagnosis Table

12.6 Enteral Nutrition Dispensing Quantity Limitations

Claims submitted for all enteral nutrition products will deny with Reject Code 76 – Plan Limitations Exceeded when the maximum quantity per dispensing and/or the maximum day supply per claim is exceeded.

Enteral nutrition products are restricted to a maximum quantity limit based on the maximum daily caloric limit for each product for a maximum of a 31-day supply. For all products, except infant products, the maximum daily caloric limit of 2,000 calories/day is used to determine the maximum quantity limit. For infant products regardless of feeding status, the maximum daily caloric limit of 800 calories/day is used. Claims submitted for quantities that exceed the limitation will require a PA request submission establishing medical necessity for the requested quantity versus the member's daily caloric need. If medical necessity cannot be established for the quantity requested, Medi-Cal Rx will have the ability to approve the request with modifications that reflect the member's daily caloric needs and any other pertinent clinical considerations that may apply. Refer to [Section 14.7 – PA Adjudication](#).

Enteral nutrition products are limited to a maximum day supply of 31 days per claim. The day supply is based on documented caloric and nutrient requirements per day, converted to a 31-day supply. A "31-day supply" is defined as the member's daily caloric requirement for product (specified by the physician on the prescription), multiplied by 31 days, divided by caloric density of product, and rounded up to the smallest available package size. Rounding up does not include rounding up to six packs or full cases of product.

$$(\text{Member's Daily Caloric Requirement} \times 31) \div \text{Product Caloric Density} = \text{Total (Rounded Up)}$$

12.7 Billing Requirements

Enteral nutrition products are only covered via Medi-Cal Rx when dispensed by a Medi-Cal Rx pharmacy provider for a contracted product with an approved PA. Claims must be submitted using the 11-digit product NDC to Medi-Cal Rx via an NCPDP electronic transaction, on the *Universal Claim Form* (refer to [Section 19.1 – Universal Claim Form, Version D.0](#)), or on the *California Specific Pharmacy Claim Form (30-1)* (refer to [Section 19.2.1 – California Specific Pharmacy Claim Form \(30-1\)](#)). Enteral nutrition products may **not** be billed on a *California Specific Compound Pharmacy Claim Form (30-4)*.

12.7.1 Medicare COB Claims

Pharmacy claims for orally administered enteral nutrition products are not a covered benefit of Medicare Part B and may be submitted directly to Medi-Cal Rx. When submitting to Medi-Cal Rx for Medicare Part B eligible beneficiaries, the claim will deny with Reject Code A6 with supplemental message *"Pharmacy to verify if beneficiary is orally or tube fed. If orally fed, resubmit the claim with DUR/PPS reason for service code "TP." Do NOT resubmit with this code if beneficiary is tube fed. Claims for tube fed beneficiaries must be billed to Medicare first."*

When the claim denies with Reject Code A6, pharmacy providers may resolve the claim by resubmitting with the following DUR codes:

- Reason for Service (NCPDP Field ID: 439-E4):
 - TP = Payer/processor Question
- Professional Services (NCPDP Field ID: 440-E5):
 - M0 = Prescriber Consulted
 - P0 = Patient Consulted
 - R0 = Pharmacist Consulted
- Result of Service (NCPDP Field ID: 441-E6):
 - 1B = Filled Prescription As Is
 - 1G = Filled Prescriber Approval

Note: These DUR codes will be accepted when claims are submitted to Medi-Cal Rx via POS, batch, web claims, or paper claims.

An approved PA is required for all enteral nutrition products. Overrides will only apply to the Medicare COB requirement and will not apply to the Medi-Cal Rx UM claim edits.

Pharmacy claims for tube-fed enteral nutrition products must be submitted as a COB claim to Medicare Part B and then Medi-Cal Rx, with the applicable OCC. Refer to [Section 10.4.1 – Medicare Part B COB Claims](#) for additional information on COB claim processing.

12.8 Shortages and Product Interchangeability

In 2022, the enteral nutrition coverage policy was temporarily updated to allow substitution of contracted enteral nutrition products without the need for a new PA request from the provider. The national formula shortage has not been resolved. As a result, this policy will continue and allow for interchangeability among contracted enteral nutrition products within the same product categories/types.

Notes:

- Interchange between different product categories/types that are not therapeutically equivalent products will require submission of a PA request.
- Quantities exceeding the maximum quantity per dispensing will require submission of a PA request (refer to [Section 12.6 – Enteral Nutrition Dispensing Quantity Limitations](#)).

12.8.1 Product Interchangeability Requirements

To qualify for interchangeability, the following requirements apply and must be documented, either physically or electronically, in the member's file:

- The substituted product must be on the [List of Contracted Enteral Nutrition Products](#).
- The substituted product must be within the same product category/type as the original product.
- The substituted product must have the same published product use as the original product (refer to the manufacturer's website for specific details).
- The substituted product must be the same kcal/gram, milliliter, or each as the original product.
- The product substituted must have the same product-specific criteria as the original product found in the [List of Contracted Enteral Nutrition Products](#).

12.8.2 Prescription Requirements

If the prescriber determines that an enteral nutrition product substitution is required and a new prescription is submitted to the pharmacy for dispensing, prescription requirements for enteral nutrition products remain unchanged (refer to [Section 12.3 – Prescription Requirements](#)).

Prescribers and pharmacy providers must meet all prescription requirements.

If the pharmacy provider determines an enteral nutrition product substitution is required and a new prescription is not submitted by the prescriber, the pharmacy provider must document the following:

- The substitution necessity; **AND**
- The date of the substitution; **AND**
- The original prescription number for the original product is now unavailable; **AND**
- The number of refills remaining on the prescription.

Once the prescription is filled with the substituted enteral nutrition product, the pharmacy provider is required to notify the prescriber that a substitution has been made due to

shortages or recalls. This notification will inform the prescriber of the updated product currently being dispensed to the member and allow the prescriber to review, evaluate, and order a change to the enteral nutrition therapy if desired.

13.0 Medical Supplies

Certain disposable outpatient medical supplies may be a covered benefit of Medi-Cal Rx when prescribed by a physician, nurse practitioner, clinical nurse specialist, or a physician assistant within the scope of their practice (California State Plan, 3.1A, 7c.1) on a written or electronic prescription. Medical supplies eligible for coverage via Medi-Cal Rx or covered products found on the lists of covered and contracted products, which can be accessed via the [Medi-Cal Rx Web Portal](#) by selecting [Contract Drugs & Covered Products Lists](#) from the **Tools & Resources** drop-down menu. Claims must be submitted with the Medi-Cal Rx 11-digit billing number, or NDC-like number, which is printed on each package (box). Products dispensed must be an exact match to a Medi-Cal Rx billing code in a list and the Medi-Cal Rx billing code submitted on the pharmacy claim submitted on the pharmacy claim menu.

Notes:

- Common household items and articles of clothing are not covered (CCR, Title 22, Section 51320).
- Listing of contracted products does **not** guarantee the product's availability.
- Refer to [Section 13.5 – Noncovered Medical Supplies](#) for information on non-listed disposable outpatient medical supplies that are not a benefit of Medi-Cal Rx.
- Refer to [Section 15.1.2 – Medical Supplies Dispensing Quantity Limitations](#) for information on quantity, frequency, and days' supply limits for covered outpatient medical supplies.

Medi-Cal Rx Covered Disposable Outpatient Medical Supplies:

The following medical supplies products are restricted to a contracted or covered *List*.

- Specific Diabetic Supplies:
 - DIDDs
 - Self-Monitoring Blood Glucose Systems (Glucometers)
 - Lancing Devices
 - Control Solutions
 - Glucose, Urine, and Ketone Test Strips
 - Lancets
 - CGM Systems
- Personal Home Blood Pressure Monitoring Devices
- Blood Pressure Cuff for Use with Personal Home Blood Pressure Monitoring Devices
- Pen Needles
- COVID-19 Antigen Tests (refer to [Section 17.3 – COVID-19 Antigen Test Kits](#))

The following covered medical supplies products are not restricted to a covered or contracted *List*. Refer to the [List of Covered Medical Supplies Product Descriptions and Billing Information](#) for product-specific information. Quantity and frequency restrictions apply, and products are reimbursed at the published MAPC for the following:

- Peak Flow Meters and Inhaler Assist Devices
- Condoms
- Basal Thermometers – For Contraception Only
- Diaphragms and Cervical Caps
- Heparin and Normal Saline Flush Solutions
- Insulin Syringes
- Alcohol Pads
- Sterile Syringes with Needles (non-insulin)

Billing Requirements for Dual Covered Medicare Part B and Medi-Cal Members:

Some medical supplies are eligible for coverage under Medicare Part B under specific conditions. When Medicare covers an item and the member is eligible for Medicare Part B, providers should bill Medicare before billing Medi-Cal Rx through COB and using the appropriate OCC when submitting the pharmacy claim. Refer to [Section 10.0 – Coordination of Benefits \(COB\)](#) for additional information.

Note: COB claims should be submitted for products on the Medi-Cal Rx covered or contracted *Lists*. Medicare Advantage secondary claims should be billed to Medi-Cal Rx on a pharmacy claim. Claims for medical supplies products not found on the Medi-Cal Rx contracted or covered *Lists* should be billed on a *CMS-1500* claim form using an HCPCS code through either CA-MMIS for FFS Medi-Cal members or through the member's Medi-Cal MCP.

Prescription Requirements for Medical Supplies:

Either a written or electronic prescription, signed and dated by the member's physician, nurse practitioner, clinical nurse specialist, or physician assistant within the scope of their practice, is required. Ordering only supplies necessary for the care of the member and as documented in the member's medical record is also required.

Note: The prescription must be dated within 12 months of the DOS on the claim (refer to [Section 4.7 – Filing Limitations](#) and its subsections).

In addition to the prescriber's signature and date prescribed, the following specific information must be supplied clearly on the prescription:

- Member's name
- Full name, address, and telephone number of the prescribing physician, nurse practitioner, clinical nurse specialist, or physician assistant, if not preprinted on the prescription form
- Product name or description of the medical supply item being prescribed
- Frequency of use
- Quantity to be dispensed

Replacement(s) for specific medical supply devices will be considered when medically necessary and/or outside of a manufacturer's warranty, **not** for recent technology upgrades. The replacement of equipment may also be considered when it has been lost or irreparably damaged. A PA request justifying replacement due to loss or irreparable damage is required.

13.1 Diabetic Testing Supplies – Test Strips, Lancets, Self-Monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices

Contracted diabetic testing supplies, including test strips (glucose and ketones), lancets, glucometers, and glucometer ancillary products, are found on the [List of Contracted Diabetic Testing Supplies](#) (which can be found on the [Medi-Cal Rx Web Portal](#) by selecting **Contract Drugs & Covered Products Lists** from the Tools & Resources drop-down menu). Product addition or inclusion on the *List* does not guarantee supply or individual specific coverage. Quantity and frequency limits apply. Medi-Cal Rx covered diabetic testing supplies are restricted to contracted products found on the List. Noncontracted items are not a Medi-Cal Rx benefit. These devices may be a benefit when billed on a medical/institutional claim using an HCPCS code to the member's respective MCP or through the Medi-Cal FFS delivery system. Prescribers and pharmacy providers should refer to the member's medical benefit for billing requirements for noncontracted Medi-Cal Rx diabetic testing supplies.

Prescription Requirements:

Medical supplies prescription requirements apply; refer to [Section 13.0 – Medical Supplies](#) for additional information. In addition, the following information must also be included on the prescription:

- A description of the item prescribed; **AND**
- The specific frequency of testing ("as needed" or "PRN" are not acceptable).

Billing Requirements:

- Reimbursement via Medi-Cal Rx is restricted to the contracted products on the [List of Contracted Diabetic Testing Supplies](#).
- When billing for test strips or lancets, claim quantities must be appropriate for the product quantity/package size (for example, 10, 25, 50, 100, 150, or 200) dispensed and are limited.
- Quantity and frequency restrictions apply. Refer to [Section 15.1.2 – Medical Supplies Dispensing Quantity Limitations](#) for additional information.
- Claims must be submitted with the contracted Medi-Cal Rx 11-digit billing number, or NDC-like number, which is printed on each package (box).
- Products dispensed must exactly match a Medi-Cal Rx billing code in the List and the Medi-Cal Rx billing code submitted on the pharmacy claim.

Quantity and Frequency Limits for Diabetic Testing Supplies:

- Maximum of one per day of each product type (one blood glucose test strip or one lancet) for a member not using insulin and no pregnancy-related diagnosis; **OR**

- Maximum of six per day of each product type (six blood glucose test strips or six lancets) for members meeting one of the following situations:
 - The member has historical paid claims for insulin with Medi-Cal Rx; **OR**
 - **Note:** If the member is a new start to insulin, pharmacy providers should submit the insulin claim first, then submit claims for diabetic test strips or lancets. This will ensure the claim is subject to the appropriate QL.
 - The member has a pregnancy-related diagnosis requiring blood glucose monitoring in their medical record with their medical benefit.
 - **Note:** Members with pregnancy-related diagnoses requiring blood glucose monitoring may continue to receive a maximum of six per day of each product during the pregnancy and up to 12 months postpartum.
 - The pharmacy provider includes one of the following pregnancy-related diagnosis ICD-10-CM codes at time of submitting blood glucose test strips or lancet claims:

ICD-10-CM Code	Diagnosis
O09	Supervision of high-risk pregnancy
O10-O16	Edema, proteinuria, and hypertensive disorders in pregnancy, childbirth, and the puerperium
O20-O29	Other maternal disorders predominantly related to pregnancy
O99	Other maternal diseases classifiable elsewhere but complicating pregnancy, childbirth, and the puerperium
Z34	Encounter for supervision of normal pregnancy

Table of Accepted Pregnancy-Related Diagnosis ICD-10-CM Codes for QLs

- For CGM device users, claim quantities are limited to 25 every 100 days for blood glucose test strips and lancets found on the [List of Contracted Diabetic Testing Supplies](#) for members with a CGM claim within 3 months, documentation of ongoing therapeutic CGM use, and a current or new PA request for a therapeutic CGM. This restriction does not apply to non-therapeutic CGM systems.

Test Strips and Lancets PA Request Requirements:

A PA request establishing medical necessity is required for coverage considerations for claims submitted to Medi-Cal Rx for quantities exceeding the QL requirements as mentioned above. The initial PA request submitted by either pharmacy providers or prescribers must include the following on the PA request:

- Diagnosis; **AND**
- Date of most recent face-to-face prescriber meeting (within six months); **AND**
- Prescriber documentation of adherence to the high utilization testing regimen; **AND**

- Most recent (within six months) Hemoglobin A1c (HbA1c) percentage and target HbA1c percent; **AND**
- Justification for high utilization of testing.

13.2 Diabetic Supplies – Disposable Insulin Delivery Devices

DIDDs may be covered by Medi-Cal Rx if it has an approved PA, meets the established requirements, and is listed on the [List of Contracted Disposable Insulin Delivery Devices](#), which can be found on the [Medi-Cal Rx Web Portal](#) by selecting **Contract Drugs & Covered Products Lists** from the Tools & Resources drop-down menu.

DIDDs are not interchangeable with insulin pumps and require a new prescription and a Medi-Cal Rx-authorized PA request for coverage. Insulin pumps are a DME benefit, not a pharmacy benefit and should not be billed to Medi-Cal Rx. Providers should bill insulin pumps and noncontracted DIDDs as a medical benefit, and the medical claims should be submitted by the provider to either the FFS FI or an MCP, as applicable. Members should contact their individual plans for coverage and billing information.

Prescription Requirements:

Medical supplies prescription requirements apply; refer to [Section 13.0 – Medical Supplies](#) for additional information. In addition, the following information must also be included on the prescription:

- Member's residence status (home, facility, etc.)
- Date of birth (DOB)

DIDDs Billing Requirements:

- Only the contracted product numbers (NDCs) on the List will be reimbursable under Medi-Cal Rx with an approved pharmacy PA; **AND**
- The package (kit or box) must not be broken apart. The entire package (kit or box) should be dispensed, and the quantity billed equals the number of pods in the package; **AND**
- Quantity and frequency restrictions apply. Refer to the [List of Contracted Disposable Insulin Delivery Devices](#) for product-specific requirements; **AND**
- PA requests may be submitted when quantity and frequency restrictions are exceeded. Documentation must clearly justify a request for additional insulin use or other medical needs if more frequent change is required.

DIDDs PA Request Requirements:

All DIDDs require a PA request with required documentation to demonstrate that the established PA request requirements and product-specific requirements are met.

Note: For claims billed for products **not** on the [List of Contracted Disposable Insulin Delivery Devices](#), a PA will **not** override and will **not** allow coverage/payment of the product. Noncovered DIDDs may be a benefit when billed on a medical/institutional claim to the member's respective MCP or through the FFS delivery system. Members should contact their individual plans for coverage and billing information.

Initial Authorization Requirements:

- HbA1c levels must be documented; **AND**
- The member is on an insulin treatment plan that requires multiple (three or more) daily insulin injections with frequent self-adjustments of the insulin dose for at least six months for members 21 years of age or older, or three months for members younger than 21 years of age prior to initiation of the device; **AND**
- The member has documented frequency of glucose self-testing an average of at least four times per day for the past two months; or has been using a CGM system for the past two months; **AND**
- The member has experienced one or more of the following while compliant on multiple (three or more) daily injections of insulin:
 - History of recurring hypoglycemia; **OR**
 - Wide fluctuations in blood glucose before mealtime; **OR**
 - Dawn phenomenon with fasting blood sugars frequently exceeded 200 mg/dl; **OR**
 - History of severe glycemic excursions.
- The device is being used for the administration of U-100 rapid acting vial insulins; **AND**
- For members residing in an LTC facility setting, clinical justification must be included and demonstrate why an insulin pump or traditional daily insulin injections administered by licensed care staff and continuous medical support reimbursed by state or federal resources does not meet the member's clinical needs.

Reauthorization Requirements:

- The member has been seen and evaluated by their prescriber no less than annually, either in-person or virtually through video or telephone conferencing; **AND**
- The member continues to meet the initial PA requirements; **AND**
- HbA1c testing is required and documented at least every 12 months.

13.3 Diabetic Supplies – CGM Systems

CGM systems may be covered by Medi-Cal Rx with an approved PA request, meeting the established requirements, and subject to contracted products on the [List of Contracted Continuous Glucose Monitoring \(CGM\) Systems](#). Noncontracted CGM systems may be a covered medical benefit through Medi-Cal MCPs. Managed care members should contact their individual plan for more information.

The initial authorization and subsequent reauthorizations are for a period of one year, initiating on the date of approval. Each fill can be up to a 90-day supply. A PA request can be submitted for any one component of the CGM system, and the approved PA request will apply to all components of the CGM system. As a result, a PA request will not be required for each component of the CGM system.

Prescription Requirements:

Medical supplies prescription requirements apply. Refer to [Section 13.0 – Medical Supplies](#). In addition, the following information must be included on the prescription:

- Member's residence status (home, facility, etc.)
- DOB

Billing Requirements:

- Packages/kits **cannot** be broken. The entire package should be dispensed where the quantity billed equals the number of devices in the package. For example, providers who would dispense a box of three sensors or one sensor would bill for quantities of three each or one each, respectively.
- Quantity, frequency, and age restrictions apply. Refer to the [List of Contracted Continuous Glucose Monitoring \(CGM\) Systems](#) for product-specific requirements and restrictions.
- Simultaneous coverage for more than one CGM system is **not** permitted.
- Claim quantities for blood glucose test strips and lancets are limited to 25 strips and lancets, each, every 100 days for contracted products found on the [List of Contracted Diabetic Testing Supplies](#) for members with a recent CGM claim for Dexcom and Abbott systems. These systems replace traditional blood glucose finger-stick testing. This restriction does not apply to Medtronic CGM systems. Urine glucose test strips and keto test strips are not impacted.

PA Request Requirements for CGM:

Initial Authorization Requirements:

A CGM PA request must meet the following requirements:

- The member meets one of the following requirements:
 - Insulin-dependence
 - The member has claims history of regularly administered insulin in the past year; **OR**
 - Documentation of regularly administered insulin use via chart notes, medical records, or additional clinical supportive documentation; **OR**
 - The member is a new start, issued a new prescription, and will be using insulin administered on a continuing and regular basis.
- History of problematic hypoglycemia with documentation demonstrating recurrent (more than one) level 2 hypoglycemic events (glucose <54 mg/dl [3.0 mmol/L]) that persist despite attempts to adjust medication(s) and/or modify the diabetes treatment plan within the past year; **or** attestation from the provider the member has problematic hypoglycemic events.
- Pregnancy-Related Diabetes Diagnoses:
 - Restricted to approval for the duration of the pregnancy and 12 months postpartum; **AND**
 - Estimated and/or actual date of delivery must be included on the request.

- A recent HbA1c value must be documented on the PA request; and the member's HbA1C value will be assessed as part of medical necessity.
- **For members residing in a care facility setting**, additional clinical justification must be included and demonstrate why traditional use of a Self-Monitoring Blood Glucose Test System administered by licensed care staff and continuous medical support reimbursed by state or federal resources does **not** meet the member's clinical needs.
- **Note:** Members using Point-of-Care diabetic supplies would **not** be eligible for approval of therapeutic CGM since it replaces standard home blood glucose monitoring.

Reauthorization Requirements:

The request must include the following:

- Documentation the member continues to meet CGM PA request coverage criteria (review above); **AND**
- The member has been seen and evaluated by the prescriber annually, either in-person or virtually through video or telephone conferencing with documentation of:
 - The date of the most recent visit; **AND**
 - A recent HbA1c value.
- For pregnancy-related diabetes diagnoses:
 - The delivery date must be included; **AND**
 - Coverage is approved for the duration of the pregnancy and up to 12 months postpartum; **AND**
 - After 12 months postpartum, a new PA request with a non-pregnancy diabetes-related diagnosis would be required; **AND**
 - Postpartum PA requests are not renewable after the end of the 12-month postpartum period. After 12 months postpartum, a new PA request with a non-pregnancy diabetes related diagnosis would be required.
- For members residing in a care facility setting, additional clinical justification must be included and demonstrate why traditional use of a Self-Monitoring Blood Glucose Test System administered by licensed care staff and continuous medical support reimbursed by state or federal resources does **not** meet the member's clinical needs.
- **Note:** Members using Point-of-Care diabetic supplies would **not** be eligible for approval of therapeutic CGM since it replaces standard home blood glucose monitoring.

Refill Requirements:

All three requirements must be met:

- Pharmacy providers are required to have contact with the member or caregiver prior to dispensing a new supply of items; **AND**
- Pharmacy providers must **not** dispense refills without a refill request from a member. Items dispensed without a valid, documented refill request will be denied as not reasonable or necessary; **AND**

- Pharmacy providers must **not** dispense a quantity of supplies exceeding a member's expected utilization, and maximum dispensing limitations apply based upon the products dispensed, utilization limitations, and requested days' supply.

13.4 Personal Home Blood Pressure Monitors and Cuffs

Personal home blood pressure monitors and blood pressure cuffs can be a pharmacy-billed benefit through Medi-Cal Rx when billed by Medi-Cal Rx eligible pharmacy providers, pursuant to the [List of Contracted Blood Pressure Monitors and Cuffs](#). Refer to the [List of Contracted Blood Pressure Monitors and Cuffs](#) for contracted products and the [List of Covered Medical Supplies Product Descriptions and Billing Information](#) for coverage criteria, quantity limitations, and additional billing information.

Note: The [List of Contracted Blood Pressure Monitors and Cuffs](#) is subject to change with notification.

Prescription Requirements:

Medical supplies prescription requirements apply. Refer to [Section 13.0 – Medical Supplies](#).

Billing Requirements:

- Claims must be submitted with the Medi-Cal Rx 11-digit billing number or the NDC-like number found on each package (box). Products dispensed must be an exact match to a Medi-Cal Rx billing code in the contracted *List* and the Medi-Cal Rx billing code submitted on the pharmacy claim.
- Only the contracted products found on the [List of Contracted Blood Pressure Monitors and Cuffs](#) will be reimbursable under Medi-Cal Rx.
 - **Note:** Some contracted products require an approved PA demonstrating medical necessity.
- Quantity and frequency restrictions apply. Refer to [Section 15.1.2 – Medical Supplies Dispensing Quantity Limitations](#).
 - **Note:** An approved PA establishing medical necessity can override quantity and frequency restrictions.
- The Maximum Acquisition Cost (MAC) is the contracted rate the manufacturer has guaranteed the product is available for purchase for dispensing to Medi-Cal Rx members by Medi-Cal Rx pharmacy providers.
 - **Note:** Providers may contact the manufacturer at the toll-free number in the [List of Contracted Blood Pressure Monitors and Cuffs](#) for information accessing products at the published Medi-Cal Rx contracted MAC price.
- For dual eligible Medicare and Medi-Cal beneficiaries, pharmacy claims for contracted products can be billed directly to Medi-Cal Rx without COB information.
 - **Note:** This is effective for claims with DOS on or after January 1, 2024.

Non-Covered Products:

Products not covered by Medi-Cal Rx include the following:

- Non-listed personal blood pressure monitors and non-listed blood pressure cuffs
- Replacement batteries
- Wrist personal blood pressure monitors and cuffs

Non-covered products may be a covered medical benefit. Medical claims for these products should be submitted to Medi-Cal FFS or the MCP on a *CMS-1500* claim form with the appropriate HCPCS code. Medi-Cal members enrolled in an MCP should contact their individual plan for coverage and billing policies for non-Medi-Cal Rx benefits.

Note: Products denied coverage by Medi-Cal Rx may also be covered by the member's medical benefit. In these situations, providers may also consider submitting a medical claim to the member's medical benefit.

13.5 Noncovered Medical Supplies

Medical supplies are a partial Medi-Cal Rx benefit, and not all medical supplies are Medi-Cal Rx benefits. Disposable outpatient medical supplies not found on the lists located on the [Contract Drugs & Covered Products Lists](#) page are not a benefit of Medi-Cal Rx. However, these non-listed medical supplies may be a benefit when billed on a medical/institutional claim to the member's respective MCP or through the Medi-Cal FFS delivery system. Members should contact their individual plans for coverage and billing information.

Medi-Cal MCPs have an obligation to provide access to non-listed or excluded Medi-Cal Rx medical supplies to their members via a medical claim. MCPs should review medical claims appropriately to determine if the medical supply is a Medi-Cal Rx noncovered or excluded product. Medi-Cal MCPs should not direct providers to bill Medi-Cal Rx for non-listed or excluded Medi-Cal Rx medical supplies.

14.0 Prior Authorization Request Overview, Request Methods, and Adjudication

14.1 PA Request Overview

Claims submitted to Medi-Cal Rx for drugs and medical supplies are subject to claim UM edits which may require authorization by Medi-Cal Rx before reimbursement can be provided.

Note: Authorization requirements are based on federal and state law.

Authorization requests are made by submitting a PA request to Medi-Cal Rx. PA requests will be accepted via the following methods:

- NCPDP P4 – Request Only
- Medi-Cal Rx Provider Portal
- CoverMyMeds
- Fax
- U.S. Mail

Note: PA requests cannot be submitted via telephone. A member **cannot** initiate or submit a PA request.

Medi-Cal Rx will ensure PA requests are reviewed and the PA submitter receives notification of determination of the PA request within 24 hours. Determination responses include approval, deferral, approval with modifications, informational, and/or denial, as directed by DHCS. Refer to [Section 14.7 – PA Adjudication](#) for additional information.

Medi-Cal Rx providers can access the Prior Authorization (PA) tab on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#) for assistance performing the following actions:

- Retrieve a copy of the designated Medi-Cal Rx PA request form(s).
- Access to a link to submit a PA request electronically through the [Medi-Cal Rx Provider Portal](#).
- Access a link to [CoverMyMeds](#) for an option to submit an ePA request.
- Access the fax number and U.S. mailing address.

14.2 NCPDP Prior Authorization (P-type) Transactions

The following subsections provide a brief overview of the allowable NCPDP Prior Authorization (P-Type) transactions.

For information regarding reject code required fields, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

14.2.1 P2 Transaction – PA Reversal

Pharmacy providers can submit a P2 – PA Reversal to back out a request for authorization. The P2 will not reverse any claims submitted against the PA request.

Paid billings should be reversed *before* the PA request is reversed.

14.2.2 P3 Transaction – PA Inquiry

A pharmacy can submit a P3 – PA Inquiry to receive a status on a *previously submitted* P1 transaction or a P4 (PA Request Only).

14.2.3 P4 Transaction – PA Request Only

P4 transactions are submitted directly from the *pharmacy* using the NCPDP layout and required fields. The pharmacy provider can request and submit a PA request on behalf of the member or provider. Registered pharmacy providers may provide additional supporting documentation by logging into the [Medi-Cal Rx Secured Provider Portal](#) to upload attachments or by faxing Medi-Cal Rx.

Note: Apart from performing a P3 transaction to receive the status of a PA request, the status will also be available on the Medi-Cal Rx Provider Portal.

14.3 Medi-Cal Rx Provider Portal for ePA Requests

The [Medi-Cal Rx Provider Portal](#) provides the ability for a pharmacy provider or prescriber's office to submit an ePA request (previously known as an eTAR). The PA submitter can view PA requests requiring additional information and will have the option to submit additional information via fax or via the Medi-Cal Rx Provider Portal.

Note: Registration is required to submit a PA request via the Medi-Cal Rx Secured Provider Portal. Refer to the [User Administration Console \(UAC\) Quick Start Guide](#) for more information on how to register for UAC.

Submission via the Medi-Cal Rx Provider Portal has a predefined intake form and utilizes the same edits that are stipulated around requirements for the above-mentioned P4 NCPDP record.

PA requests received via the Medi-Cal Rx Provider Portal can include any additional attachments (for example, patient records or lab work) that the PA submitter deems pertinent for the request to establish medical necessity. Once Medi-Cal Rx reviews the PA request and a determination is made, a faxed response will be sent to the requestor.

Note: The status of the PA request will be available on the Medi-Cal Rx Provider Portal. Visibility of a status may take up to 24 hours.

The following table identifies how the status will be displayed in the Medi-Cal Rx Provider Portal along with the status note.

Prior Authorization Status	
Displayed Status	Prior Authorization Status
Approved	PA request is approved as requested.
	PA request is approved with modification(s).
Change in Therapy	Provider chose alternate therapy. PA request is closed.
Denied	PA request has been denied.
In Progress	Additional information needed. View PA response in Portal.
	PA request is in progress.
Closed	PA request has been closed.

Notes:

- A "Change in Therapy" status indicates that a provider elects to prescribe an alternate medication that does not require a PA and essentially withdraws the PA request.
- A "Closed" status indicates that a PA request is closed as informational. Refer to [Section 14.7 – PA Adjudication](#) for details about informational determination.

14.4 CoverMyMeds for ePA Requests

Medi-Cal Rx's prescriber community can submit an ePA request utilizing the CoverMyMeds platform. CoverMyMeds can be accessed at www.covermymeds.health.

Note: Only a *prescriber* can submit a completed PA request directly through CoverMyMeds. Pharmacy providers may *initiate* a PA request through CoverMyMeds. If the prescriber utilizes CoverMyMeds to submit PA requests, the initiated PA request will be visible for the prescriber's office to complete.

CoverMyMeds interacts in real time with the Medi-Cal Rx vendor's POS claims processing system and with the Medi-Cal Rx vendor's Clinical Decision Module (CDM) to present covered alternatives and collect required clinical information from the prescriber. The CDM incorporates lists of drugs requiring a PA request with alternatives that do not require authorization, diagnostic information, age and gender considerations, or quantity limitations. The CDM enhances the ability to determine whether medical necessity has been met by presenting a series of questions for determination of the PA request. The CDM is built using clinically based guidelines where Medi-Cal Rx policy will take precedence.

Depending on the responses provided to the CDM questions, the PA request can be approved in real time. If a real-time approval cannot be determined, the PA request will be routed to Medi-Cal Rx for further review and determination. Once Medi-Cal Rx reviews the PA request and a determination is made, a faxed response will be sent to the PA submitter. The PA submitter will not receive a faxed response when a real-time approval is received in CoverMyMeds.

Notes:

- PA requests received via CoverMyMeds can include any additional attachments (for example, patient records or lab work) that the PA submitter deems pertinent for the request to establish medical necessity.
- PA requests submitted through other channels will not display in CoverMyMeds. The status of the PA request will be available on the [Medi-Cal Rx Provider Portal](#). Visibility of a status may take up to 24 hours.

For more information, refer to the [Medi-Cal Rx: CoverMyMeds® How-To Guide](#) available on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#).

14.5 Fax PA Submissions

Medi-Cal Rx accepts PA requests that are submitted via fax. Faxed requests must be submitted on one of the following forms (refer to [Appendix E – Acceptable Medi-Cal Rx PA Request Forms](#)):

- *Medi-Cal Rx Prior Authorization Request Form* (preferred)
- *Medi-Cal Rx Enteral Nutrition Prior Authorization Request form* (for enteral nutrition PA requests only)
- Medi-Cal Form 50-1
- Medi-Cal Form 50-2
- California Form 61-211

Note: The *Medi-Cal Rx Prior Authorization Request Form* and the *Medi-Cal Rx Enteral Nutrition Prior Authorization Request form* are available on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#).

PA requests submitted by fax must be complete, legible, and include any relevant medical justification, as well as administration location when applicable. Medi-Cal Rx also requires providers or their designees to sign and date all PA requests. An original signature is required on all forms. The signature must be written, not printed. Stamps, initials, typed, or facsimile signatures are not acceptable. When signing, use a ballpoint pen.

PA requests received by fax can include any additional attachments (for example, patient records or lab work) that the PA submitter deems pertinent for the request to establish medical necessity. Once Medi-Cal Rx reviews the PA request and a determination is made, a faxed response will be sent to the requestor.

Note: All pages/attachments that a provider sends in a single fax transaction are received together.

PA requests can be sent by fax to Medi-Cal Rx at 1-800-869-4325. If the fax submission is unsuccessful, the provider should double-check that the fax number is correct. If after two attempts the fax is unsuccessful, the provider should contact the CSC by telephone (1-800-977-2273) for further directions.

Note: The status of the PA request will be available on the [Medi-Cal Rx Provider Portal](#). Visibility of a status may take up to 24 hours.

14.6 U.S. Mail

Medi-Cal Rx will accept PA requests that are received by U.S. mail. Mailed requests must be submitted on one of the following forms (refer to [Appendix E – Acceptable Medi-Cal Rx PA Request Forms](#)):

- *Medi-Cal Rx Prior Authorization Request Form* (preferred)
- *Medi-Cal Rx Enteral Nutrition Prior Authorization Request form* (for enteral nutrition PA requests only)
- Medi-Cal Form 50-1
- Medi-Cal Form 50-2
- California Form 61-211

Note: The *Medi-Cal Rx Prior Authorization Request Form* and the *Medi-Cal Rx Enteral Nutrition Prior Authorization Request form* are available on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#).

PA requests received by mail must be complete, legible, and include any relevant medical justification, as well as administration location when applicable. Medi-Cal Rx also requires providers or their designees to sign and date all PA requests. An original signature is required on all forms. The signature must be written, not printed. Stamps, initials, typed, or facsimile signatures are not acceptable. When signing, use a ballpoint pen.

PA requests received by mail can include any additional attachments (for example, patient records or lab work) that the PA submitter deems pertinent for the request to establish medical necessity. Once Medi-Cal Rx reviews the PA request and a determination is made, a faxed response will be sent to the requestor.

Notes:

- If the PA requestor does not have a fax number, Medi-Cal Rx will mail a written confirmation with the outcome.
- PA requests submitted by U.S. mail will be received by the Medi-Cal Rx mail room and handled in the same manner and process as a faxed PA request (refer to [Appendix B – Directory](#) for the mailing address). The status of the PA request will be available on the Medi-Cal Rx Provider Portal. Visibility of a status may take up to 24 hours.

14.7 PA Adjudication

Upon receipt of a PA request, Medi-Cal Rx will first determine eligibility and program coverage by reviewing eligibility factors, including but not limited to the following:

- Program eligibility
- Residence status
- Existence of authorized prescribers
- Existence of program coverage restrictions, as well as other elements specified and approved by DHCS

Once eligibility is confirmed, Medi-Cal Rx will review the DUR information available to the clinician along with the information submitted with the PA request. Review of a PA request will result in one of the following determinations:

- **Approval:** If the information furnished by the PA submitter establishes medical necessity, an approval is documented. The authorization is sent to the POS system in real time so that it is available for claim adjudication. An authorization number is not required for the claim to adjudicate.
 - The authorization will be approved for an appropriate duration, based on medical necessity and DHCS guidelines.
 - The PA submitter will receive a fax and/or correspondence communicating the PA request determination, except in the case of a real-time approval via CoverMyMeds.
- **Approved with Modifications:** If the information furnished by the PA submitter established medical necessity but the approval is modified from the original request (strength, quantity, dosage form, etc.) by Medi-Cal Rx, an approval with modifications is documented.
 - The authorization will be approved for an appropriate duration, based on medical necessity and DHCS guidelines.
 - The PA submitter will receive a fax and/or correspondence communicating the PA request determination, except in the case of a real-time approval via CoverMyMeds.

- An Approved with Modifications determination will generate a Notice of Action (NOA) to the requesting PA submitter and member. Medi-Cal Rx will mail the appropriate notice within three business days.
- **Deferred:** If Medi-Cal Rx is not able to establish medication necessity from the information furnished by the PA submitter, the PA requested will be deferred with a request that additional information be provided by the PA submitter.
 - The PA submitter will be given the reason for the deferral by fax and the PA request will be in a deferred status for up to 30 days. If a fax number is not available and the request **was not** submitted electronically, a letter will be mailed. If a fax number is not available and the request **was** submitted electronically, the status of the PA request will be available via the Medi-Cal Rx Provider Portal.
 - At the end of the 30 days, if no additional information is received or medical necessity cannot be established from the additional information received, an NOA will be sent to the PA submitter, authorized representative (if applicable), and member indicating the PA request was denied.
 - **Note:** To reduce the need to defer, the PA submitter should provide all pertinent information and rationale to establish medical necessity, such as diagnosis and corresponding ICD-10-CM code, tried and considered alternatives with reason for failure, contraindication or intolerance, lab results with dates, and quantity and days' supply requested.
- **Denial:** If the information furnished by the PA submitter does not meet medical necessity, a denial is documented.
 - Final determinations of a denial will be made by DHCS. DHCS has the ability to approve a PA request that was recommended for denial by Medi-Cal Rx.
 - **Note:** Denial determinations made by Medi-Cal Rx on behalf of DHCS between 4 p.m. PT on Friday and 5 a.m. PT on Monday, on observed holidays, and any other DHCS-designated time period where DHCS assigns Medi-Cal Rx delegation, may be overturned by DHCS if deemed appropriate.
 - A Denial will generate an NOA to the requesting PA submitter and member. Medi-Cal Rx will mail appropriate notice within three business days.
- **Informational:** If, upon review of the information furnished by the PA submitter, Medi-Cal Rx determines the product requested does not require an authorization, the request is a duplicate, or the request cannot be accepted, the PA request will be determined as informational.
 - The reason a PA request cannot be accepted may include, but is not limited to, the following: invalid PA request form; invalid signature; invalid client index number (CIN), HAP ID, or BIC ID; drug not found; Medi-Cal Rx is not considered a payer of the claim, etc.
 - The PA submitter will receive a fax and/or correspondence communicating the PA request determination along with the reason for the determination.

14.8 PA Appeal Requests

If a PA request has been denied due to inability to establish medical necessity, a PA submitter may appeal the determination by submitting a PA appeal request. The PA submitter has 180 days to submit an appeal from the date of the initial denial. If the 180th day falls on a Saturday, Sunday, or holiday, the final date to submit the appeal will be the next business day. PA appeal requests are accepted via the Medi-Cal Rx Provider Portal and via paper by fax or U.S. mail. The request must explicitly be noted as an appeal by stating the word "Appeal," or by the provider selecting the appeal option via submission via the Medi-Cal Rx Provider Portal. Refer to [Appendix B – Directory](#) for mailing addresses and fax numbers to submit a provider PA appeal request. Medi-Cal Rx will send an Appeal Acknowledgement correspondence to the PA submitter via fax or mail (when fax is unavailable) within one calendar day of a PA appeal request.

Note: Unless specifically noted as an appeal, a second PA request submitted for a previously denied request is treated as a new review only if new information is provided. If no new information is provided, the request is treated as a duplicate. If a PA request has been denied due to no response on a deferred PA request and a PA appeal request has been submitted, the request will be treated as new.

Provider appeal requests must contain the date or service being appealed, the reason the appeal should be granted, and any additional documentation to support the appeal.

Medi-Cal Rx will review claims history, all past clinical information, and new information submitted to make a determination on the appeal request. Medi-Cal Rx will ensure PA appeal requests are reviewed within 60 days and the PA submitter receives notification of determination of the PA appeal request.

Note: The Medi-Cal Rx vendor will send NOA letters to the provider, member, and authorized representative (when applicable) within three business days from the date of the action requiring a letter.

15.0 Program Specifications

15.1 Limitations

15.1.1 Dispensing Quantity Limitations

Refer to the following table for information on DHCS' days' supply dispensing policies and refill limitations.

Note: Certain drugs may have exceptions to the days' supply limits or have specific quantity limitations that supersede the rules described in *Table 15.1.1-1* below.

Description	Standard Limitation	Comments
Days' Supply	Prescription quantities must not be greater than a 100-calendar day supply.	<p>Examples of Exceptions:</p> <ul style="list-style-type: none"> • Oral Contraceptives <ul style="list-style-type: none"> – Can be filled for up to 365 days (1-year supply) at a time. • Self-administered hormonal contraceptives • When a greater days' supply is necessary to bypass the 100-calendar day supply limitation for a specific drug. <p>Note: Providers with questions regarding days' supply and days' supply exceptions can call the CSC at 1-800-977-2273 for assistance.</p>

Table 15.1.1-1: Dispensing Quantity Limitation Rules

15.1.2 Medical Supplies Dispensing Quantity Limitations

Refer to *Table 15.1.2-1* below for dispensing limitations regarding medical supplies. Providers should submit a PA request for quantities outside of/exceeding the limitations.

Medical Supply	Limitation(s) without a PA Request
Basal Thermometer	1 per 365-day period
Cervical Cap, for contraceptive use, each	2 per 365-day period; 1 per dispensing
Contraceptive supply, condom, female, internal, each	No more than 12 per claim and no more than 2 claims per 90-day period.
Contraceptive supply, condom, male, each	36 per 30-day period
Diaphragm, contoured for contraceptive use	1 per 365-day period
Diaphragm, wide seal for contraceptive use	1 per 365-day period
Disposable Insulin Delivery Devices	<p>PA request only.</p> <ul style="list-style-type: none"> • For Omnipod, no more than 30 pods per 90-day period • For V-Go, no more than 90 pods per 90-day period.

Medical Supply	Limitation(s) without a PA Request
Inhaler, Assist Devices (spacer, bag, or reservoir, with or without mask, for use with metered dose inhaler)	2 per 365-day period
Peak Flow Meters, Non-Electronic	1 per 365-day period
Alcohol Prep Pads	200 per 30-day period
Blood Pressure Cuffs	1 per 365-day period
Personal Home Blood Pressure Monitoring Devices	1 every 5 years
Blood glucose test strips	<ul style="list-style-type: none"> Maximum of 1 per day for a member not using insulin and no pregnancy-related diagnosis; OR Maximum of 6 per day for a member using insulin or pregnancy-related diagnosis. <p>Refer to Section 13.1 – Diabetic Testing Supplies – Test Strips, Lancets, Self-Monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices for additional information.</p>
Blood ketone test strips	30 strips in a 90-day period
Urine test strips	50 strips in a 90-day period
Lancets	<ul style="list-style-type: none"> Maximum of 1 per day for a member not using insulin and no pregnancy-related diagnosis; OR Maximum of 6 per day for a member using insulin, or pregnancy-related diagnosis. <p>Refer to Section 13.1 – Diabetic Testing Supplies – Test Strips, Lancets, Self-Monitoring Blood Glucose Systems (Glucometers), Control Solutions, and Lancing Devices for additional information.</p>
Glucometers	2 every 5 years
Glucose control solution	1 per 365-day period
Lancing devices	1 per 365-day period
Pen needles	Up to 6 per day and a maximum of 4 fills every 100 days

Medical Supply	Limitation(s) without a PA Request	
Syringes, Insulin U-500	Up to 3 per day and a maximum of 4 fills every 100 days. Regular Insulin U-500 units/ml vials require the use of U-500 insulin syringes for safe administration; pharmacist must counsel on use of appropriate syringes with insulin 500-U/ml vials when dispensed.	
Syringes, Insulin, any size	Up to 6 per day and a maximum of 4 fills every 100 days	
Sterile Syringes with Needles (non-insulin)	Up to 6 per day for specific sizes and a maximum of 4 fills every 100 days.	
CGM Systems	Receiver/Reader	PA request only. 1 every 1 to 3 years, as published on the List of Contracted Continuous Glucose Monitoring (CGM) Systems .
	Transmitter	PA request only. 1 every 90 days to 365 days, as published on the List of Contracted Continuous Glucose Monitoring (CGM) Systems .
	Sensor	PA request only. Up to 2 to 5 every 30 days, as published on the List of Contracted Continuous Glucose Monitoring (CGM) Systems .

Table 15.1.2-1: Medical Supplies Dispensing Quantity Limitations

15.1.3 Controlled Substance Policy

Claims for all controlled substances, including opioids (DEA Schedule II-V) will have a **maximum days' supply** of 35 days. A PA request will be required for claims submitted for greater than 35 days.

Note: This limit does **not** apply to new start opioid prescriptions.

New start opioid claims will be restricted to a 7-day supply or a maximum **quantity** of 30 solid dosage units (each) or 240 ml for liquids.

Claims submitted for controlled substances will be restricted to the following utilization limits:

Controlled Substance Utilization Limits			
Description	Max Day Supply	Quantity Limitation	Refill Threshold
All Controlled Substances (except opioids, benzodiazepines, buprenorphine)	35	Refer to the CDL for specific drugs where applicable.	75%
Benzodiazepines *	35	Daily quantity: 8 each (solid) or 240 ml (liquid). Refer to the CDL for additional limit(s) where applicable.	75%
Buprenorphine products indicated for pain	35	Refer to the CDL for specific drugs where applicable.	75%
Buprenorphine products indicated for Opioid Use Disorder	35	Sublingual dosage daily limit: 32 mg. Refer to the CDL for additional limit(s) where applicable.	75%
Opioid New Start ** (Absence of opioid therapy in the past 90 days prior to the current claim's DOS. Cough preparations containing opioids are excluded from the opioid drug lookback.)	7	Max Dispense quantity: 30 each (solid) or 240 ml (liquid).	90%
Opioid Chronic Therapy ** (Presence of opioid therapy in the member's history within the prior 90 days. Opioid therapy lookback includes long-acting, short-acting, and buprenorphine products. Cough preparations containing opioids are excluded from this lookback.)	35	500 MME	90%
* Limitations for benzodiazepine do not apply to special populations, except for the 75% refill threshold.			
** Limitations for opioids do not apply to special populations, except for the 90% refill threshold.			

Table 15.1.3-1: Controlled Substance Utilization Limits

15.1.4 Opioid Limitations

Effective June 1, 2024, any claims with cumulative morphine milligram equivalents (MME) less than 500 will not deny nor generate a warning message for excessive dose risk. When 500 MME has been exceeded, the claim will deny and require a PA request.

The established MME thresholds will apply cumulatively, across all concurrent opioid prescriptions, allowing refill variance(s) equal to an early refill (ER) tolerance of 90 percent, indicated by a number of days (for example, 90 percent is 3 days early on a 30-day supply).

Note: New start is defined as the absence of paid claims for opioids in the past 90 days prior to the current claim's DOS; cough preparations containing opioids are excluded from this lookback. Subsequent fills or chronic use is defined as the presence of a paid claim for opioid therapy (including long-acting, short-acting, and buprenorphine products) in the past 90-day period.

The submission of DUR codes (refer to the [Prospective DUR](#) link on the [Drug Use Review](#) page on the [Medi-Cal Rx Provider Portal](#)) will be allowed to override ER reject(s) for opioids.

The above limitations outlined in *Table 15.1.3-1* for opioids, with the exception of the 90 percent refill threshold, will not apply to members who are:

- In LTC facilities.
- In hospice.
- Receiving palliative or end-of-life care.
- Diagnosed with sickle-cell disease.
- In treatment for active cancer-related pain.

15.1.5 Benzodiazepine Limitations

All claims submitted for benzodiazepines will be limited to a maximum of a 35-day supply and a daily limit of 8 each solid or 240 ml liquid dosage units. This limitation, also outlined in *Table 15.1.3-1* for benzodiazepine, with the exception of the 75 percent refill threshold, will not apply to members who:

- Have a documented history or submitted diagnosis of seizure disorders.
- Require treatment of status epilepticus.
- Are in hospice.
- Are receiving palliative or end-of-life care.

Refer to the [CDL](#) for any additional utilization limit where applicable.

15.1.6 Buprenorphine Limitations

All claims submitted for buprenorphine products will be limited to a maximum of a 35-day supply and a 75 percent refill threshold. Buprenorphine products indicated for opioid use disorder treatment will have a daily limit of 32 mg for sublingual products. Refer to the [CDL](#) for any additional utilization limit where applicable.

15.2 Partial Fills

Medi-Cal Rx will not accept partial fills.

- Claims submitted with the Dispensing Status code of 'P – Partial Fill' will deny with Reject Code RK – Partial Fill Transaction Not Supported.

15.3 Incremental Fills

Required by CA AB1048, a single prescription for a DEA Schedule II drug may be filled in multiple increments on separate claims (known as an incremental fill) only if **all** of the following conditions are met:

- All incremental fills must be processed by the same pharmacy.
- Total quantity dispensed for all incremental fills must not exceed the total quantity prescribed by the prescriber.
- Any quantity remaining on the prescription after 30 days from the date prescribed cannot be filled.

15.4 Claims Processing Edits

Once a claim has been submitted online by a pharmacy, the POS system will return a message to indicate the outcome. If the claim passes all edits, a PAID message will be returned with the allowed reimbursement amount. A claim that fails an edit(s) and is REJECTED or DENIED will return with a reject code and message. Refer to [Appendix D – NCPDP Reject Codes](#) for a list of reject codes.

Note: For paper claims that have been submitted *and* processed, the claim outcome will be visible via the POS system, Provider Portal, or on the RA.

15.5 Dispense as Written (DAW) Codes

The Medi-Cal Rx vendor will accept the dispense as written (DAW) codes in *Table 15.5-1* below. DHCS will allow any DAW code to be submitted on the claim, but use of a DAW code will not override any claim edits (such as pricing or PA requirement(s)). For example, a PA may still be required when a brand name drug is prescribed.

DAW Code	DAW Description	Action
DAW 0	No Product Selection Indicated	Allowed
DAW 1	Substitution Not Allowed by Prescriber	Allowed
DAW 2	Substitution Allowed-Patient Requested Product Dispensed	Allowed
DAW 3	Substitution Allowed- Pharmacist Selected Product Dispensed	Allowed
DAW 4	Substitution Allowed- Generic Drug Not in Stock	Allowed
DAW 5	Substitution Allowed-Brand Drug Dispensed as a Generic	Allowed
DAW 6	Override	Allowed

DAW Code	DAW Description	Action
DAW 7	Substitution Not Allowed-Brand Drug Mandated by Law	Allowed
DAW 8	Substitution Allowed-Generic Drug Not Available in Marketplace	Allowed
DAW 9	Substitution Allowed by Prescriber but Plan Requests Brand	Allowed

Table 15.5-1: Allowed DAW Codes

15.6 Cost Ceiling

Claims submitted to Medi-Cal Rx are subject to the cost ceiling claim edit Reject Code 78 – Cost Exceeds Maximum. To improve pharmacy claim submission and processing quality and to mitigate potential FWA in Medi-Cal Rx, the previous \$10,000 cost ceiling policy has been revised to the following cost ceiling categories as outlined in *Table 15.6-1*:

Cost Ceiling Limits		
Drug/Product	Identifier	Value Per Claim
Over-the-Counter (OTC)	OTC	\$50
Generic	Generic	\$1,000
Single and Multisource Brand	Brand	\$4,000
High-Cost Drug (HCD) – Generic and Brand	HCD	\$14,000

Table 15.6-1: Cost Ceiling Limits

Note: Cost ceiling limits impacting drugs for the NDCs provided on the [Medi-Cal Rx Approved NDC List](#) are categorized by the following Cost Ceiling Limit Identifiers:

- **OTC:** Over-the-counter products where the claim threshold amount is equal to or greater than \$50.
- **Generic:** Generic drugs where the claim threshold amount is equal to or greater than \$1,000.
- **Brand:** Brand, multisource drugs where the claim threshold amount is equal to or greater than \$4,000 when the claim is submitted with a DAW 1. These claims will be subject to Brand Medically Necessary (BMN) PA requirements.
 - **Note:** Claims without a DAW 1 will be evaluated based on the Generic cost ceiling limit.
- **HCD:** High-cost generic and brand drugs, not in the Generic or Single and Multisource Brand categories, where the claim threshold amount is equal to or greater than \$14,000.
- **Excluded:** Drugs excluded from the cost ceiling limits.
 - **Note:** Other products excluded from cost ceiling limits include specific disposable medical supplies, diabetic testing supplies, COVID-19 antigen tests, enteral nutrition products, OTC insulin, and drugs submitted as a compound claim.

PA Request Requirements

Claims will deny with Reject Code 78 when the cost ceiling limit is exceeded with the supplemental message "[*\$XX.00*] *Maximum Cost Exceeded. Call CSC (1-800-977-2273) for inquiries or submit a Prior Authorization.*"

Providers should consider prescribing a less costly therapy, if clinically appropriate. If a change in therapy is not appropriate, a PA request establishing medical necessity is required for coverage considerations for claims submitted to Medi-Cal Rx for claims exceeding the cost ceiling limits.

15.7 Emergency Fills

15.7.1 Emergency Dispensing of 14-Day Supply

Beginning February 6, 2022, dispensing of a 14-day emergency supply of all products that are Medi-Cal Rx benefits for which delays in access to therapy due to UM claim edits would withhold a medically necessary service is permitted electronically and via paper claim.

Pharmacy Emergency Dispensing is exempt from PA request or Code I requirements. The pharmacist shall self-certify the emergency existed in accordance with CCR, Title 22, Section 51056(c). Emergency fills will be subject to audits, and providers are required to retain documentation of the emergency circumstances for audit purposes.

Electronically billed emergency claims will be limited to a 14-day supply and a limit of two fills in a 30-day period for the same product and dose. Claims must be submitted at POS using the Level of Service (LOS) value of '3 – Emergency' to indicate it is an emergency claim (refer to [Medi-Cal Rx Billing Tips](#) for additional information). When an emergency claim is submitted for unbreakable packages such as inhalers, vials, oral contraceptives, etc., the claim will deny with the supplemental message "*Pharmacist certification of emergency service: For Emergency Fill for an unbreakable package covering more than a 14-day supply submit submission clarification code (SCC) = 65.*" Emergency claims for unbreakable packages submitted with LOS = 3 and SCC = 65 will continue to be paid for the full package size even when the days' supply exceeds 14 days.

Notes:

- If the emergency situation requires a dispensed quantity to exceed a 14-day supply for breakable packages, the provider must submit a paper claim for the service.
- Any policy reject codes may be overridden for emergency purposes with the exception of any eligibility edits (including those with an SOC) and OHC reject codes.
- For DOS prior to February 6, 2022, electronically billed emergency drug dispensing claims were limited to a 3-day supply and a limit of two fills in a 30-day period for the same drug and dose.

15.7.2 Emergency Dispensing for Out-of-State Providers

A PA request is required for **all** out-of-state services, except for emergency services as defined in CCR, Title 22, Section 51056(c).

15.7.3 Protocol for Overriding UM During State of Emergency

During a Federal, State, or locally declared state of emergency, DHCS may authorize providers to override specific claims edits. The authorization may apply to specific counties and/or specific populations as directed by DHCS.

DHCS will notify providers when state of emergency overrides are activated via the [Medi-Cal Rx Web Portal](#), including any applicable restrictions.

15.8 Physician Administered Drugs (PADs)

A PAD is an outpatient drug that is typically administered to a member and billed by a health care provider in locations that include, but are not limited to, physician's offices, clinics, and hospitals, and are not self-administered by a member or caregiver. If a drug is administered by a health care provider other than a pharmacy provider in a pharmacy setting, and not self-administered by the member or caregiver even if the drug is FDA-approved for self-administration, that drug would primarily be considered a medical benefit by merit of the administration by a medical provider. Therefore, the same policy pertaining to other non-self-administered drugs (that is, those not FDA-approved for self-administration) would apply. As such, PADs not administered by a pharmacy provider in a pharmacy setting or dispensed for self-administration are considered a medical benefit.

15.8.1 Coverage

PADs eligible for coverage via Medi-Cal Rx are found on the [Medi-Cal Rx Contract Drugs List](#) (CDL) and the [Medi-Cal Rx Pharmacy Reimbursable Physician Administered Drugs](#) list. Refer to the Covered Products Lists tab on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#). Medi-Cal Rx claim UM edits may apply for PADs found on these lists. If UM edits apply, pharmacies will only be reimbursed by Medi-Cal Rx with an approved PA request and the claim billed pursuant to claim field requirements provided in the *Medi-Cal Rx NCPDP Payer Specification Sheet* (refer to [Appendix A – NCPDP Payer Specification Sheet](#)).

15.8.2 Reject Code 816

Medi-Cal Rx will deny claims for PADs that should be submitted as a medical claim to the member's respective MCP or through the Medi-Cal FFS delivery system when applicable. These claims will reject with Reject Code 816 – Pharmacy Benefit Exclusion, May Be Covered Under Patient's Medical Benefit with the supplemental message "*Pharmacy Drug Benefit Exclusion. Exception for pharmacy benefit approval may be considered via PA request. May be covered as a medical benefit.*"

PADs with Reject Code 816 PA Request Requirements:

An exception for coverage of PADs with Reject Code 816 via Medi-Cal Rx may be considered upon PA request submission. Certain situations that may warrant an exception, requiring a claim and PA request submission for the PAD to Medi-Cal Rx, may include but are not limited to the following:

- The medical provider is unable to access a specific PAD, and the provider must obtain it from a local or mail-order pharmacy for administration.
- The PAD will be dispensed by the pharmacy provider and be administered via home infusion.
- The manufacturer has limited the distribution of the PAD to certain specialty pharmacies and/or distributors of specialty drugs.
- The member requires immediate access to the PAD and the administering provider is unable to provide the PAD and bill it as a medical claim.

If an exception is warranted, the PAD PA request will be assessed for medical necessity. The following information must be included on the PA request submission:

- If a PA request is submitted for PADs, providers must include rationale for why the PAD must be billed as a pharmacy claim to Medi-Cal Rx and cannot be billed as a medical claim to the medical benefit for coverage; **AND**
- Providers must include clinical rationale to determine medical necessity for PAD therapy.

It is important to remember that exceptions will be made on a case-by-case basis via a Medi-Cal Rx approved PA request and only when absolutely necessary. Once a PA request is approved by Medi-Cal Rx, a pharmacy provider may order, fill, and submit a pharmacy claim for the PAD. The PAD may then be sent to an administering provider to administer the drug appropriately.

15.8.3 MCP Obligation

Medi-Cal members should not be directed to obtain PADs from a pharmacy unless the PAD is found on the CDLs or [Medi-Cal Rx Pharmacy Reimbursable Physician Administered Drugs](#) list or there is a warranted exception. PA request approvals of PADs billed by pharmacy providers are not intended to replace PAD coverage as a medical benefit. PADs will always remain a medical benefit even when made available as a pharmacy benefit on a case-by-case basis. If a medical provider bills for a pharmacy drug as part of a medical visit or incidental to a medical visit, it should be treated as a medical claim, even if the drug is typically considered a pharmacy drug. MCPs should not deny such claims on the basis of their classification as a pharmacy claim. It is important to recognize that such claims are, in fact, medical claims and should be treated as such.

15.9 Pharmacy Administered Immunizations/Vaccines

California law authorizes pharmacists to administer immunizations pursuant to a legal prescription, a protocol with a prescriber (*Business and Professions Code* [Bus & Prof Code] *Section 4052*), or pharmacist initiated pursuant to Bus & Prof Code, *Section 4052.8* and CCR, Title 16, *Section 1746.4*. Pharmacy administered immunizations or vaccines covered by Medi-Cal Rx can be found in the [CDL](#) (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**).

Note: Immunizations and vaccines are both a Medi-Cal covered pharmacy benefit and a Medi-Cal covered medical benefit.

Medi-Cal Ordering, Referring, and Prescribing (ORP) Providers

Individual pharmacists must be Medi-Cal ORP providers in order to bill for services. It is a federal requirement that state Medicaid agencies require all ordering or referring physicians, or other professionals providing services under the State plan or under a waiver of the plan, to be enrolled as participating providers pursuant to 42 *Code of Federal Regulations* (CFR), *Section 455.410(b)*. Refer to the [Ordering/Referring/Prescribing Only Enrollment Information](#) page for additional information on ORP enrollment.

Note: Pharmacists without an NPI and who are not enrolled as an ORP provider may administer vaccines as long as the prescriber NPI submitted on the pharmacy claim to Medi-Cal Rx is enrolled as an ORP provider. This includes prescribers independently initiating and administering vaccines or ordering prescriptions for FFS Medi-Cal recipients.

Coverage

Immunizations/vaccines covered as a Medi-Cal Rx pharmacy benefit for members 19 years of age and older are found in the CDL, otherwise they are covered under the member's medical benefit(s). Medi-Cal Rx claim UM edits apply and a PA request submission establishing medical necessity is required for coverage considerations.

Note: Medi-Cal members 18 years of age and younger are eligible for the Vaccines For Children (VFC) program. Refer to *Section 15.9.1 – Vaccines For Children Program* and the [Medi-Cal Reimbursement of Vaccines For Children \(VFC\)-Enrolled Pharmacy Providers and for VFC and Non-VFC Vaccines – Frequently Asked Questions \(FAQs\)](#) for additional information.

Reimbursement

Pharmacy claims submitted to Medi-Cal Rx for vaccines are reimbursed for the ingredient cost, professional dispensing fee, and administration fee.

- Ingredient cost is reimbursed in a similar method as other pharmacy claims (refer to [Section 4.6.1 – Legend and Non-Legend Drugs](#) for reimbursement information).
- A professional dispensing fee is also paid for FFS pharmacy reimbursement (refer to [Section 4.6.2 – Professional Dispensing Fee](#)).

- A vaccine administration fee is also paid for FFS pharmacy reimbursement when utilized pursuant to the guidelines published by the CDC for members 19 years of age and older (refer to [Section 4.6.18 – Vaccine Administration Fee](#)).

Evaluation and Management services associated with initiating the prescription (Bus & Prof Code, Section 4052.8 and CCR, Title 16, Section 1746.4) must be billed as a medical claim to either the MCP or FFS Medi-Cal, whichever is applicable. For FFS Medi-Cal claims, refer to [Section 15.12 – Pharmacist Services](#) billing instructions.

15.9.1 >>Vaccines For Children Program

As of January 1, 2023, the VFC program is a Medi-Cal pharmacy benefit that covers all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP). Vaccines are available to Medi-Cal members 18 years of age and younger free of charge through the VFC program. Pharmacies who are Medi-Cal providers and wish to administer VFC-funded vaccines to VFC-eligible Medi-Cal members must enroll in the VFC program.

Note: The claim submission is under the pharmacy, not the individual pharmacists, since pharmacists are not enrolled as the billing provider.

Coverage

Vaccines covered as a Medi-Cal Rx VFC pharmacy benefit for members 18 years of age and younger are found in the CDL. Medi-Cal Rx claim UM edits apply for pharmacies not enrolled in the VFC program submitting a claim for members 18 years of age and younger.

Reimbursement

Reimbursement of pharmacy claims submitted to Medi-Cal Rx by pharmacies enrolled in the VFC program for the professional dispensing fee and administration fee is outlined as follows:

- Professional dispensing fee
 - Reimbursement logic will apply a \$13.20 or \$10.05 professional dispensing fee based on the pharmacy's total (both Medicaid and non-Medicaid) annual claim volume (refer to [Section 4.6.2 – Professional Dispensing Fee](#) for additional information).
- >>DHCS will reimburse for the VFC vaccine administration at the lesser of the billed amount or \$9.00. To receive the professional services administration fee, the pharmacy provider must identify that the pharmacy is administering the vaccine and enter the applicable values in the following NCPDP fields:
 - Enter the dollar amount of the administration fee in the Incentive Fee Amount Submitted field (NCPDP Field ID: 438-E3).
 - Select the following Reason for Service Code (NCPDP Field ID: 439-E4):
 - PH = Preventive Health Care
 - Select the following Professional Service Code (NCPDP Field ID: 440-E5):
 - MA = Medication Administration

- Select the following Result of Service Code (NCPDP Field ID: 441-E6):
 - 3N = Medication Administration

Note: If any or all of these fields are left incomplete or blank, claims will continue to adjudicate, but pharmacy providers will not be reimbursed for the professional services administration fee. Refer to the [Medi-Cal Reimbursement of Vaccines For Children \(VFC\)-Enrolled Pharmacy Providers and for VFC and Non-VFC Vaccines – Frequently Asked Questions \(FAQs\)](#) for additional information.

Consultation and assessment services associated with the vaccine initiation fee must be billed as a medical claim to either the MCP or FFS Medi-Cal, whichever is applicable.

15.10 Intravenous or Intra-Arterial Solutions

Simple Intravenous (I.V.) solutions are typically used for hydration therapy. Commercially available (non-compounded) solutions such as Normal Saline, Dextrose (up to 10 percent in Water) and Lactated Ringer's Solution, as well as commercially prepared solutions of potassium chloride in such solutions are included in this definition. Simple I.V. solutions should be billed using the product's NDC number.

Parenteral Nutrition Solutions (Total Parenteral Nutrition [TPN] or Hyperalimentation):

These solutions are restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when I.V. therapy with the same product was started before discharge without a prior authorization (PA). There is a maximum of 10-day supply per dispensing within this 10-day period.

Parenteral nutrition solutions are intravenously or intra-arterially administered nutritional products that are typically suspensions or solutions of amino acids or protein, dextrose, lipids, electrolytes, vitamin and/or mineral supplements, and trace elements.

Adjuncts to parenteral nutrition are other drugs which are physically mixed into a parenteral nutrition solution at any time prior to administration. Bill for these products as part of the parenteral nutrition billing.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Note: Claims submitted to Medi-Cal Rx for a parenteral nutrition solution dispensed within 10 days following inpatient discharge can be submitted using SCC 57 – Discharge Medication for a 10-day supply. Providers may submit a PA request with clinical rationale establishing medical necessity for coverage considerations for a days' supply exceeding 10 days.

Separately Administered I.V. Lipids:

These solutions are restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when I.V. therapy with the same product was started before discharge without a PA. There is a maximum of 10-day supply per dispensing within this 10-day period.

I.V. lipid solutions or suspensions that are administered separately from parenteral nutrition solutions (that is, are not physically mixed into the parenteral nutrition solution container) should be billed using the product's NDC number.

Note: Claims submitted to Medi-Cal Rx for a separately administered I.V. lipid solution dispensed within 10 days following inpatient discharge can be submitted using SCC 57 – Discharge Medication for a 10-day supply. Providers may submit a PA request with clinical rationale establishing medical necessity for coverage considerations for a days' supply exceeding 10 days.

I.V. Solutions of Unlisted Antibiotics:

Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when I.V. therapy with the same antibiotic was started before discharge without a PA. There is a maximum of 10-day supply per dispensing within the 10-day period.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Note: Claims submitted to Medi-Cal Rx for I.V. solutions of unlisted antibiotics dispensed within 10 days following inpatient discharge can be submitted using SCC 57 – Discharge Medication for a 10-day supply. Providers may submit a PA request with clinical rationale establishing medical necessity for coverage considerations for a days' supply exceeding 10 days.

I.V. Solutions of Other Unlisted Drugs:

Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when I.V. therapy with the same drug was started before discharge without a PA. There is a maximum of 10-days' supply per dispensing within the 10-day period.

Note: Non-compounded products must be billed using the product's NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Note: Claims submitted to Medi-Cal Rx for I.V. solutions of other unlisted drugs dispensed within 10 days following inpatient discharge can be submitted SCC 57 – Discharge Medication for a 10-day supply. Providers may submit a PA request with clinical rationale establishing medical necessity for coverage considerations for a days' supply exceeding 10 days.

Sterile Transfers:

Restricted to dispensing within 10 days following inpatient discharge from an acute care hospital when I.V. therapy with the same drug was started before discharge. There is a maximum of 10-day supply per dispensing within the 10-day period.

The following sterile transfers require a PA:

- Creating “unit-dose” injections from multiple dose products, regardless of time of discharge.
- Claims for more than seven containers, regardless of the 10-day post-discharge window or Contract Drugs List status.

Note: Non-compounded products must be billed using the product’s NDC number. Compounded solutions must be billed as a compound claim. For information regarding specific fields that must be entered for successful transmission of transactions, refer to [Appendix A – NCPDP Payer Specification Sheet](#).

Note: Additional information on I.V. Administration Sets for FFS members can be found in the Medical Supply section of the [DHCS Provider Manual \(Part 2\)](#).

15.11 Blood and Blood Derivatives

Blood Factors: Billing for Bleeding and Clotting Disorders:

Pharmacies must bill blood factor products using the NDC via a pharmacy claim form. Attachments are not required. Pharmacies may submit claims for clotting factors via POS or paper claim form.

For reimbursement information related to Blood and Blood Derivatives refer to [Section 4.6.16 – Blood and Blood Derivatives Reimbursement](#).

Contracted Providers:

To meet the unique specialized care needs of the Medi-Cal Rx population who utilize specialty drugs, only contracted providers are eligible to provide contract blood factors to Medi-Cal, CCS, and GHPP members. A list of the contracted specialty providers who are eligible to provide those blood factors included in the contract blood factor list is available on the DHCS website (<https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/BloodFactors.aspx>).

Coagulation factors for bleeding disorders, such as hemophilia, represent the first class of specialty drugs to utilize provider contracts. These products are identified in W&I Code 14105.86(a)(2)(A). The DHCS will contract with any specialty pharmacy that will sign a contract to meet a list of performance obligations. These include, but are not limited to, delivery time requirements, providing patient education and submitting quarterly and yearly reports to DHCS.

Providers who wish to enroll as Specialty Contracted Providers for clotting factor(s) must enroll through the PED by submitting enrollment form MC3155 – Medi-Cal Specialty Pharmacy Provider Application. This form can be found in the Forms section of the DHCS website (<https://mcweb.apps.prd.cammis.medi-cal.ca.gov/references/forms>).

For information on contracted clotting factors refer to the CDL on the [Medi-Cal Rx Web Portal](#).

Continuing Care:

Medi-Cal Rx will provide reimbursement for blood factors marked “authorization required” only with an approved PA request or the member qualifies for continuing care. To be eligible for continuing care and exemption from the authorization requirement, the following conditions must be met:

- The member must be taking the drug when it is suspended or deleted from the [Medi-Cal Rx Contract Drugs List – Blood Factors](#).
- The Medi-Cal Rx vendor must have received a claim for the drug, in the same dosage form and strength, within 100 days prior to the drug’s end date or suspension. The [Medi-Cal Rx Provider Portal](#) will allow a provider to look up a member and view that member’s claims (only showing claims for the NPI of the provider who logged in). Any member claims history is only available via the Medi-Cal Rx Provider Portal after a provider has securely logged in to the [Medi-Cal Rx Secured Provider Portal](#).

To maintain member eligibility under continuing care, a claim must be submitted for the drug, in the same dosage form and strength, at least every 100 days from the DOS. The member may switch between brands of the drug in the same dosage form and strength and maintain their continuing care status.

15.12 Pharmacist Services

Pursuant to Assembly Bill (AB) 1114, Chapter 602, Statutes of 2016 added W&I Code, Section 14132.968, DHCS is required to establish reimbursement and policy for pharmacist services, provided to a Medi-Cal recipient. These services include:

- Furnishing naloxone.
- Furnishing self-administered hormonal contraception.
- Initiating and administering immunizations.
- Furnishing nicotine replacement therapy.
- Furnishing travel medications.

Note: The services mentioned above **are not** a Medi-Cal Rx benefit. These services must be billed using applicable CPT codes on a *CMS-1500* health claim form, **NOT** a pharmacy claim (submitted via POS or paper).

For additional information and billing requirements, refer to the [DHCS Provider Manual \(Part 2\)](#) on the DHCS site.

15.13 Authorized Drug Manufacturer Labeler Codes

Providers will only be reimbursed for drugs made by manufacturers identified in the [Medi-Cal Rx Contract Drugs List – Authorized Drug Manufacturer Labeler Codes](#) (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**). If a claim is submitted for a nonauthorized labeler code, providers will not be reimbursed.

15.14 Compound Processing

Compound claims may be submitted via the POS system, batch file submission, WCS, a UCF (refer to [Section 19.1 – Universal Claim Form, Version D.0](#)), or a *California Specific Compound Pharmacy Claim Form (30-4)* (refer to [Section 19.2.2 – California Specific Compound Pharmacy Claim Form \(30-4\)](#)).

Any component of a compound requiring a PA will necessitate an approval prior to receiving payment.

Prescribed drugs listed in the CDL (which can be found on the [Medi-Cal Rx Provider Portal](#) by selecting **Forms & Information** and then **Covered Products Lists**) and unlisted drugs approved by authorization that require special compounding by the pharmacist are covered by Medi-Cal Rx, provided that the name of the product(s), quantity of the ingredient(s), and valid NDC(s) of each ingredient are listed on the claim.

Note: Select medical supplies, diabetic supplies, enteral nutrition products, and blood factors may not be billed on a *California Specific Compound Pharmacy Claim Form (30-4)*.

The *California Specific Pharmacy Claim Form (30-1)* must be completed for non-compounded I.V. solutions.

The *California Specific Compound Pharmacy Claim Form (30-4)* must be completed for compounded I.V. solutions or sterile transfers.

Note: If providers are submitting a *California Specific Compound Pharmacy Claim Form (30-4)*, Box 48 (Specific Details/Remarks) **must** have the SNOMED value of the claim.

Refer to the important notes for compound claim submission in *Table 15.14-1* below.

#	Description
1	Compounds will be processed using the Multi-Ingredient Compound functionality as provided by NCPDP version D.0.
2	The Claim Segment Product ID (which is the NDC) is defined as a mandatory field and, therefore, must be submitted for all claims, including multi-ingredient compounds.
3	A nonblank space value is expected in the Claim Segment Product ID field for field validation. The pharmacy submits '0' zero in this field for a multi-ingredient compound. For compound segment transactions, the claim is rejected with the appropriate NCPDP response reject code and message if zero is not submitted as the Product ID.

#	Description
4	<p>SCC 8 only allows a claim to continue processing if at least one ingredient is covered. Nonapproved labeler ingredients will process with the SCC; but only approved labeler ingredients are eligible for reimbursement. NDCs that require authorization will not receive a payment unless a provider resubmits the claim after an approved PA has been granted.</p> <p>Note: For compound claims where an ingredient in the compound also has a Code I restriction, both the SCC = 8 <i>and</i> the SCC = 7 will have to be billed on the same claim. Alternatively, providers have the option to submit the applicable ICD-10-CM diagnosis code on the incoming claim to satisfy the Code I Restriction (refer to Section 11.1 – Code I Restrictions). Providers may contact the CSC at 1-800-977-2273 for assistance regarding SCCs.</p>
5	Pharmacies must transmit the same NDC numbers that are being used to dispense the medication.
6	All compounds must contain at least two ingredients. The Medi-Cal Rx vendor will accept up to 25 ingredients. Compound claims with <i>more</i> than 25 ingredients will not be accepted and will deny with Reject Code 9K – Cmpd Ing Component Cnt Exceeds Num Ing Supported.
7	Single ingredient compound claims will not be accepted. These claims will deny with Reject Code 7Z – Compound Requires Two or More Ingredients with the supplemental message <i>"Compounds must contain at least two ingredients. Compounds with container NDC must also include at least one active compounded ingredient."</i>
8	<p>Based on the submitted ingredient cost data per ingredient, if the total submitted ingredient cost on the claim is not equal to the sum of the ingredients' costs, the claim will deny.</p> <p>Example: A compound with two ingredients is submitted for a total claim cost of \$50. Ingredient A has a submitted cost of \$20 and Ingredient B has a submitted claim cost of \$10; the claim will deny because the sum of the submitted claim cost for both ingredients (A & B) totaled \$30, but the total claim cost was indicated to be \$50.</p>
9	Multiple instances of an NDC within a compound will not be allowed. These claims will deny with Reject Code 21 – M/I Product/Service ID with the supplemental message <i>"Duplicate compound ingredients are not allowed."</i>
10	Duplicate Edits are applied to compounds.

#	Description
11	<p>For ProDUR processing, the compounds are matched on the number of ingredients and same ingredients. Excipient drugs are excluded from the comparison logic.</p> <p>Excipient Drugs/Products include:</p> <ul style="list-style-type: none"> • Sodium/Saline Preparations • I.V. Solutions: Dextrose Water • Water • Irrigants • Flavorings • Cream bases • Ointment bases
12	<p>SNOMED is a required field for compounds – the route of administration is required – NCPDP # ROUTE OF ADMINISTRATION (Field # 995-E2)</p> <p>Note: If providers are submitting a <i>Compound Claim Form</i> (30-4), Box 48 (<i>Specific Details/Remarks</i>) must have the SNOMED value of the claim. If providers are submitting a UCF, Field 66 must have the SNOMED value of the claim.</p>
13	<p>There are dispensing fees applicable for compounds. Refer to Section 4.6.7 – Compound Prescriptions for compound claim reimbursement information.</p>
14	<p>Coverage for compounds is the same as non-compounds with exceptions. There are specific products that are not allowed in compounds.</p> <p>The products not allowed in compounds are:</p> <ul style="list-style-type: none"> • Blood Factors • Bulk Ingredients • Condoms • Control Solutions • Diabetic Supplies • Diaphragms/Cervical Caps • Enteral Nutrition Products • Glucometers • Heparin Saline Flush • Incontinence Supplies • Inhaler Assist Devices • Lancing Devices • Medical Supplies • Nutritionals • Pen Needles • Peak Flow Meters <p>These products used within a compound will deny with Reject Code 70 – Product/Service Not Covered with the supplemental message "<i>Ingredient used is not covered within a compound.</i>"</p>

#	Description
16	<p>The container NDC 9999999997 is to be submitted on claims unless it is for a non-injectable compound. The maximum allowed containers submitted per claim on an injection/infusion compound is 20, without prior authorization. If a claim is submitted with more than 20 containers and there is not an approved PA, the claim will deny with Reject Code 76 – Plan Limitations Exceeded with the supplemental message <i>"Compound container limit exceeded. Prior Authorization Required."</i></p> <p>Note: If the container NDC is not submitted on an injectable or infusion compound, adjudications will assume one container.</p>
17	<p>Compounds are not a covered benefit of Family PACT. These claims will deny with Reject Code 7Y – Compounds Not Covered with the supplemental message <i>"Compounds are not a covered benefit of FPACT."</i></p>

Table 15.14-1: Compound Claim Submission Notes

Note: Refer to [Appendix A – NCPDP Payer Specification Sheet](#) for fields required for claim submission using the POS system.

15.15 Mass Claim Adjustment(s)

Automated claim adjustments are an integrated part of the claim process and will allow re-adjudication with new and/or corrected rules or parameter settings applied that will reverse and rebill claims with the corrected values. The mass claim adjustment process includes identifying the impacted claims by applying a predetermined set(s) of parameters, reversing them, and then reprocessing the transaction to correct the issue.

Mass claim adjustment requests are initiated (typically by DHCS) for any one or more of the following reasons:

- Drug Pricing
- Drug Coverage
- Provider Dispensing Fee Rates
- SOC
- Eligibility
- COB

15.16 Electronic Prescribing (ePrescribing)

Electronic Prescribing (ePrescribing) is the use of an automated data entry system to generate a prescription, replacing the use of handwritten prescriptions.

Electronic prescriptions are computer-generated prescriptions created by the prescriber and sent directly to the member's pharmacy of choice. ePrescribing applications that are certified by SureScripts (the industry leader in ePrescribing), allow new prescription orders and refill authorizations from the prescriber to be sent directly to the computers of the selected pharmacies.

15.16.1 ePrescribing Process

Instead of writing the prescription on a piece of paper, the prescriber enters it directly into an automated data entry system to the pharmacy's computer using a private, secure, and closed network. The ePrescribing process eliminated the need for the member to take a hard copy of the prescription to the pharmacy, saving time and facilitating prescription accuracy.

The Medi-Cal Rx vendor has contracted with SureScripts, the industry leading vendor for ePrescribing.

General information on activated pharmacies with ePrescribing capabilities and that utilize SureScripts within California can be found at www.surescripts.com. Physicians interested in automating the prescribing process must utilize an ePrescribing or Electronic Medical Record (EMR) system that has been certified to connect to the Pharmacy Health Information Exchange, operated by SureScripts.

15.17 End of Life Option Act Services

The End of Life Option Act is a California Law that permits terminally ill adult recipients with the capacity to make medical decisions to be prescribed an aid-in-dying medication if certain conditions are met.

The law is outlined in California *Health and Safety Code* (H&S Code), Division 1, Part 1.85, Section 443.

15.17.1 Pharmacy Billing for End of Life Option Act Services

Medi-Cal Rx will not cover end of life services. End of life services claims submitted via the POS system, UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4) are not permitted and will be denied.

Pharmacies must bill for end of life services on the *CMS-1500* claim form only. Providers can refer to the [DHCS Provider Manual \(Part 2\)](#) for additional information on the End of Life Services Act and billing information.

16.0 Drug Use Review (DUR)

16.1 DUR Program Overview

Federal rules require that each state Medicaid program include a comprehensive Drug Use Review (DUR) program to improve the quality and cost effectiveness of drug use by ensuring that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical results.

California's Medicaid DUR program is focused on outpatient medication therapies with the broad goals of improving patient outcomes, increasing the quality of prescribing practices, reducing healthcare costs, and improving member, prescriber, and pharmacist satisfaction. To work towards these goals, the DUR program implements strategies that identify and reduce

adverse events, fraud, misuse, overutilization, underutilization, and inappropriate/ineffective care associated with specific drugs or groups of drugs. Strategies for improving prescribing medications may include education, data reports, audits, alerts, incentives, decision-making tools, and outreach aimed at members, prescribers, and pharmacists.

There are three key functions of the DUR program Prospective DUR:

- Retrospective DUR
- Educational Outreach
- Information on the three functions above can be found on the [Medi-Cal Rx Provider Portal](#) by selecting Tools and Resources, and then selecting [Drug Use Review](#).

Central to the DUR program is the Global Medi-Cal DUR Board, which is an advisory board that includes volunteer pharmacists and physicians with active practices in California. The Board advises and makes recommendations to the State on common drug therapy problems; develops criteria to evaluate and improve the quality of drug therapy, reviews, evaluations, and utilization reports; and recommends educational interventions, as needed, in order to improve prescribing and dispensing practices.

The DUR program promotes patient safety through state-administered UM tools and systems that interface with the claims processing systems. Additional, consistent with 42 CFR Section 438.3(s)(4) and (5), the Centers for Medicare & Medicaid Services (CMS).

Note: Prospective (concurrent) DUR edits will apply to all real-time claim types (such as POS or Web). Edits will not apply to Paper and Batch claims. Also, prior April 1, 2021, claim adjudication would allow submission of only the major conflict code to satisfy all DUR conflicts on the claim. Effective April 1, 2021, the pharmacy must submit each DUR conflict code on the claim.

Claims that deny for DUR will deny with Reject Code 88 – DUR Reject Error.

16.1.1 Medi-Cal Rx DUR/PPS Codes for Opioid MME Alert

The following 'HC' Reason for Service code in *Table 16.1.1-1* may be submitted for a single MME claim or cumulative MME across multiple claims where the MME is greater than 90 and less than 500.

Reason for Service Code (NCPDP Field ID: 439-E4)

Value	Description	Definition
HC	High Cumulative Dose	Detects high cumulative drug dose(s) for a single MME claim, or across multiple claims that fall above the standard dosing range.

Table 16.1.1-1: Reason for Service Code (NCPDP Field ID: 439-E4)

Professional Service Code (NCPDP Field ID: 440-E5)

In addition to codes accepted for other ProDUR alerts (refer to the [Prospective DUR](#) link on the [Drug Use Review](#) page on the [Medi-Cal Rx Provider Portal](#)), for Opioid MME alerts, the Medi-Cal Rx vendor will also accept the following codes in *Table 16.1.1-2*:

Value	Description	Definition
CC	Coordination of care	Case management activities of a pharmacist related to the care being delivered by multiple providers.
DE	Dosing evaluation/ determination	Cognitive service whereby the pharmacist reviews and evaluates the appropriateness of a prescribed medication's dose, interval, frequency and/or formulation.
DP	Dosage evaluated	Code indicating that dosage has been evaluated with respect to risk for the patient.

Table 16.1.1-2: Professional Service Code (NCPDP Field ID: 440-E5)

Result of Service Code (NCPDP Field ID: 441-E6)

In addition to codes accepted for other ProDUR alerts (refer to the [Prospective DUR](#) link on the [Drug Use Review](#) page on the [Medi-Cal Rx Provider Portal](#)), for Opioid MME alerts, the Medi-Cal Rx vendor will accept the following codes in *Table 16.1.1-3*:

Value	Description	Definition
4B	Dispensed, Palliative Care	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because it is being used for palliative care.
4C	Dispensed, Hospice	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient is in hospice.
4D	Dispensed, Cancer Treatment	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient has or is being treated for cancer.
4E	Dispensed, Chronic Pain	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient is being treated for chronic pain.
4F	Dispensed, Exempt Per Prescriber	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription due to an exemption as written/communicated by the prescriber.

Value	Description	Definition
4G	Dispensed, Surgery/Trauma	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription, because the patient is having or has had a major surgery or trauma.
4H	Dispensed, Hospital Admission/Discharge	The pharmacist reviews and evaluates a therapeutic issue (alert) and dispenses the prescription because the patient is being admitted to or is being discharged from a hospital.
4J	Dispensed, Patient is Not Opioid Naïve	Patient medication history demonstrates patient is not opioid naïve based on clinical guidelines, medication prescribed/dispensed without change.

Table 16.1.1-3: Result of Service Code (NCPDP Field ID: 441-E6)

16.2 >>Patient Counseling Requirements

Pursuant to FEDERAL STATUTORY REQUIREMENT: Section 1927(g)(2)(ii)(I) of the Act, the pharmacist is required to discuss with each Medicaid member or a caregiver, in person whenever practicable, or by toll-free telephone for long distance calls, matters which, in their professional judgment, the pharmacist deems significant. Such counseling is subject to standards for counseling to be established under state law (*State Pharmacy Practice Act*). Such counseling is to be provided unless refused by the Medicaid member or caregiver.

The statute lists the following subjects for inclusion in counseling:

- The name and description of the medication.
- Dosage form, dose, route of administration, and duration of drug therapy.
- Special directions and precautions for preparation, administration, and use by the patient.
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including how they may be avoided, and the actions required if they occur.
- Techniques for self-monitoring drug therapy.
- Proper storage.
- Prescription refill information.
- Action to be taken in the event of a missed dose.

Impact on Pharmacies

Pharmacy providers must observe the following guidelines regarding counseling:

- The pharmacist is responsible for personally conducting the counseling in accordance with the requirements of the California State BOP, CCR, Title 16, Section 1707.2.
- Counseling requirements apply to both new and refill prescriptions, except in situations where the patient's agent is not readily available to receive a counseling offer or the counseling itself.

- Documentation in the form of a signature by the patient or patient's agent is required only if counseling is refused and must be retained in the pharmacy for at least one year from the date of making.
- >>Pharmacies are exempt from signature requirements for the dispensing of drugs during the COVID-19 public health emergency (PHE) and Southern California Wildfires PHE.
- Pharmacies whose primary patient population is accessible through local measures or toll-free exchange are not required to offer toll-free service for long distance calls.

16.2.1 Patient Record Keeping (Medication Records)

Pursuant to FEDERAL STATUTORY REQUIREMENT: Section 1927(g)(2)(A)(ii)(II) of the Act, the pharmacist is required to make a reasonable effort to obtain, record, and maintain for Medicaid members the following information:

- Name, address, phone number, age (or birth date), and gender.
- Individual history where significant, including disease state(s), known allergies, drug reactions, a comprehensive list of medications and relevant devices.
- Pharmacist's comments relevant to the individual's drug therapy.

Impact on Pharmacies

The pharmacist is responsible for collecting, recording, and maintaining the above patient medication record information in accordance with the requirements of the California State BOP, CCR, Title 16, Section 1707.1.

The pharmacist may rely upon ancillary personnel to collect, record, and obtain patient information for their medication record, but the pharmacist must review and interpret that information and clarify confusing or conflicting information.

It is expected that the pharmacist will be guided by professional judgment as to whether and when individual history information should be sought from the patient's physician or other health care providers.

16.3 Automatic Refill Programs for Members

In general, a pharmacy may offer a program to automatically refill prescriptions to members, provided the pharmacy complies with CCR Title 16, Section 1717.5.

Note: CGM systems are excluded from the automatic refill program. Refer to [Section 13.4 – Personal Home Blood Pressure Monitors and Cuffs](#).

1. A pharmacy may offer a program to automatically refill prescriptions provided the pharmacy complies with this section.
 - a. The pharmacy shall have written policies and procedures describing the program, which shall set forth, at a minimum, how the pharmacy will comply with this section.
 - b. Before a member enrolls, the pharmacy shall provide a written or electronic notice summarizing the program to the member or member's agent. Such notice shall include, at a minimum, instructions about how to withdraw a prescription medication from refill through the program or to disenroll entirely from the program. The

member or member's agent shall enroll by written, online, or electronic informed consent to participate in the program for each new prescription, or there is a change in the prescription medication, strength, dosage form, or directions for use.

- c. For each prescription to be refilled through the program, the pharmacy shall obtain annual renewal of each prescription from the member or member's agent no later than 12 months after the prescription was enrolled in the program.
 - d. The pharmacy shall keep a copy of the written or electronic informed consent to enroll on file for one year from date of dispensing.
 - e. The pharmacy shall complete a drug regimen review for each prescription refilled through the program at the time of refill.
 - f. Each time a prescription is refilled through the program, the pharmacy shall provide a written or electronic notification to the member or member's agent confirming that the prescription medication is being refilled through the program.
 - g. The member or member's agent shall at any time be able to withdraw a prescription medication from automatic refill or to disenroll entirely from the program. The pharmacy shall document and maintain such withdrawal or disenrollment for one year from the date of withdrawal or disenrollment and shall provide confirmation to the member or member's agent.
 - h. The pharmacy shall provide a full refund to the member, member's agent, or payer for any prescription medication refilled through the program if the pharmacy was notified that the member did not want the refill, regardless of the reason, or the pharmacy had been notified of withdrawal or disenrollment from the program prior to dispensing the prescription medication.
 - i. A pharmacy shall make available any written or electronic notification required by this section in alternate languages as required by state or federal law.
2. A licensed health facility, as defined in *Health and Safety Code* (H&S Code), Section 1250, that automatically refills prescriptions for its members need not comply with the provisions of H&S Code, Section 445.
 3. Pharmacies automatically refilling prescriptions for inmates of an adult correctional facility or a juvenile detention facility need not comply with the provisions of this section if the facility has written policies and procedures describing how a member may request that a medication be automatically refilled and how a member may refuse the medication.

Notes:

- Authority Cited:
 - Bus & Prof Code, Section 4052
- Reference:
 - Bus & Prof Code, Sections 4001.1, 4005, 4063 and 4076.6
 - H&S Code, Section 1250

17.0 COVID-19 Vaccines, Antigen Test Kits, and Therapeutics: Coverage and Reimbursements

Effective September 11, 2023, FDA-approved COVID-19 vaccines supplied by the federal government will transition to the commercial market.

The vaccines are not supplied for free by the federal government for most members.

Medi-Cal Rx will pay for the updated commercial COVID-19 vaccines as a pharmacy benefit for all members 3 years of age and older.

Note: For members 6 months up to 3 years of age, coverage of the vaccine will be available only through the VFC program. Claims submitted to Medi-Cal Rx for members younger than 3 years of age will deny with Reject Code 60 – Product/Service Not Covered For Patient Age with supplemental message *“Product only available through a Vaccines for Children (VFC) provider for children under 3. To locate an eligible provider, see <https://eziz.org/> or call 1-877-243-8832. Age requirement not met. Prior Authorization Required.”*

Uninsured and underinsured adults may obtain free COVID-19 vaccines through [CDC's Bridge Access Program](#). The vaccines can be accessed through local pharmacies and health care providers, including Federally Qualified Health Centers (FQHCs). For additional details, refer to the guidance from the CDPH's [California Bridge Access Program](#).

Medi-Cal Rx will pay for the COVID-19 vaccine as a pharmacy benefit under the following guidelines:

- For vaccine(s) provided by the federal government, coverage will apply to members under Medi-Cal Rx, Family PACT, CCS, and GHPP. The vaccines are outlined in the [CDLs](#) on the [Medi-Cal Rx Web Portal](#).
- An SCC is required for submission on incoming claims for COVID-19 vaccines in order to document which dose is being administered and what incentive fees to apply (refer to [Section 17.1 – COVID-19 Vaccine Administration Reimbursement](#) for additional information on incentive fees).
 - **SCC 2 – Other Override** should be used to identify the initial dose of the vaccine.
 - **SCC 6 – Starter Dose** should be used to identify the second dose of the vaccine.
 - **SCC 7 – Medically Necessary** should be used to identify the third dose of the vaccine.
 - **SCC 10 – Meets Plan Limitations** should be used to identify the booster dose of the vaccine.
- For paper claims (UCF or 30-1), pharmacy providers are directed to populate the fill number based on the dose:
 - “0” to indicate the first dose of the Primary series is being administered and billed.
 - “1” to indicate the second dose of the Primary series is being administered and billed.

- “3” to indicate the third dose for immunocompromised is being administered and billed.
- “4” to indicate that a booster dose is being administered and billed.
- OHC edits will remain applicable to COVID-19 vaccine claims (refer to [Section 10.0 – Coordination of Benefits \(COB\)](#) and corresponding subsections for additional information).
- COVID-19 vaccine coverage is applicable to members in all outpatient/ non-correctional resident locations.
 - **Note:** This is not applicable to the additional in-home incentive fee (refer to [Section 17.2 – COVID-19 Supplemental Incentive Fee Reimbursement for In-Home Vaccine Administration](#)).
- Any prescriber ID (NPI) may be billed on the claim.
 - **Note:** Claim submitted using a sanctioned or deceased prescriber will continue to reject.
- COVID-19 vaccines will be a carve-out for MCP members for all plans.
- Pharmacy providers should bill the claim with a Basis of Cost Determination (NCPDP field ID: 423-DN) of “15 – Free Product or No Assoc Cost” when the pharmacist self-initiates the COVID-19 vaccine.
 - **Note:** Pharmacy providers are not required to submit a Basis of Cost Determination on COVID-19 vaccine claims.
- Beginning January 1, 2022, pharmacy providers should bill the claim utilizing the following DUR code values (refer to [Section 16.0 – Drug Use Review \(DUR\)](#) and corresponding subsections for additional information):
 - Reason for Service Code (NCPDP field 439-E4): PH – Preventive Health Care
 - Professional Service Code (NCPDP field 440-E5): MA – Medication Administration
 - Result of Service Code (NCPDP field 441-E6): 3N – Medication Administration
 - **Note:** Pharmacy providers are not required to submit these DUR codes on COVID-19 vaccine claims.
- Additional information regarding fields required for claim submission can be found in [Appendix A – NCPDP Payer Specification Sheet](#).

17.1 >>COVID-19 Vaccine Administration Reimbursement

The American Rescue Plan Act of 2021 (ARPA) period ended on September 30, 2024. Effective October 1, 2024, the Medi-Cal Rx reimbursement for COVID-19 vaccines is as follows.

- Ingredient cost (refer to [Section 4.6.1 – Legend and Non-Legend Drugs](#) for reimbursement information)
 - **Note:** VFC-enrolled pharmacy providers will not receive reimbursement for the ingredient cost when claims are submitted for members 18 years of age and younger.

- Professional dispensing fee (refer to [Section 4.6.2 – Professional Dispensing Fee](#) for fee amount)
- Administration fee:
 - >>VFC-enrolled pharmacy providers will receive \$9 for the administration fee or lesser of the billed amount when claims are submitted for members 18 years of age and younger. The pharmacy must submit \$9 in the administration fee field (NCPDP FIELD ID – 438-E3) in order to be reimbursed the administration fee.
 - Non-VFC-enrolled pharmacy providers will receive \$34 for the administration fee or lesser of the billed amount when claims are submitted for members 3 years of age to 18 years of age. The pharmacy must submit \$34 in the administration fee field (NCPDP FIELD ID – 438-E3) in order to be reimbursed the administration fee.
 - VFC and Non-VFC-enrolled pharmacy providers will receive \$34 for the administration fee or lesser of the billed amount when claims are submitted for members 19 years of age and older. The pharmacy must submit \$34 in the administration fee field (NCPDP FIELD ID – 438-E3) in order to be reimbursed the administration fee.
- >>**For retroactive pharmacy claims with a DOS on or after September 11, 2023, through September 30, 2024**, Medi-Cal Rx will reimburse pharmacy providers for the following costs:
 - Ingredient cost (refer to [Section 4.6.1 – Legend and Non-Legend Drugs](#) for reimbursement information)
 - >>**Note:** VFC-enrolled pharmacy providers will not receive reimbursement for the ingredient cost when claims are submitted for members 18 years of age and younger.
 - \$40 administration fee for commercial COVID-19 vaccines
 - **Notes:**
 - Providers will not be reimbursed a professional dispensing fee for commercial COVID-19 vaccines.
 - An SCC is not required for the claim submission for commercial COVID-19 vaccines.
- >>**For retroactive pharmacy claims with a DOS on or after March 15, 2021, through September 10, 2023**, Medi-Cal Rx will reimburse pharmacy providers for the \$40 administration fee.
 - **Note:** Pharmacy claims will not be reimbursed for ingredient cost or professional dispensing fee.

17.2 COVID-19 Supplemental Incentive Fee Reimbursement for In-Home Vaccine Administration

For pharmacy claims with a DOS on or after June 8, 2021, through September 30, 2024, Medi-Cal Rx will reimburse providers an additional \$35 per dose when administering a COVID-19 vaccine in the home of a Medi-Cal member who is unable to travel to a vaccination site.

Note: The *additional* in-home incentive fee will only be reimbursed if the *sole purpose* of the in-home visit is to administer a COVID-19 vaccine. The *additional* in-home incentive fee will **not** be reimbursed if another service is provided in the same home on the same date; in those instances, providers will only be reimbursed for the standard incentive fee as outlined in [Section 17.1 – COVID-19 Vaccine Administration Reimbursement](#).

Many types of locations can qualify as a member's home for the additional in-home incentive fee amount, such as:

- A private residence
- Temporary lodging (for example, a hotel or motel, campground, hostel, or homeless shelter)
- An apartment in an apartment complex
- A unit in an assisted living facility or group home
- A Medicare member's home that has been made provider-based to a hospital during the COVID-19 PHE

The following locations **do not** qualify as a home for the additional in-home incentive fee amount:

- Communal spaces of a multiunit living arrangement
- Hospitals (except when the Medicare member's home has been made provider-based to a hospital during the COVID-19 PHE)
- Skilled nursing facilities (SNFs), regardless of whether or not they are the member's permanent residence

The reimbursement of the *additional* in-home incentive fee is limited to the following:

- 2 claims in six months for DOS on or after June 8, 2021, to August 11, 2021
- 3 claims in seven months for DOS on or after August 12, 2021, to September 21, 2021
- 4 claims in seven months for DOS on or after September 22, 2021, to January 2, 2022
- 4 claims in six months for DOS on or after January 3, 2022

If providers are administering a COVID-19 vaccine to *more than one member* in a single home on the *same day*, the following incentive fee reimbursement will be applied:

For pharmacy claims with a DOS on or after August 25, 2021, through September 30, 2024, the additional in-home incentive fee amount of approximately \$35 may be billed up to *five* times when *multiple members* are vaccinated in the *same home* on the *same DOS* if administering the vaccine to fewer than 10 members.

- For example, if a provider is administering six vaccines on the same date to six members in the same home, the provider will be reimbursed approximately \$415 (5 × \$35 for the in-home vaccine incentive fee rate plus 6 × \$40 [standard incentive fee as previously outlined in [Section 17.1 – COVID-19 Vaccine Administration Reimbursement](#)] for each dose of the COVID-19 vaccine administered).

For pharmacy claims with a DOS on or after October 1, 2024, Medi-Cal Rx will not reimburse providers the additional in-home incentive fee of \$35 as the ARPA period ended on September 30, 2024.

Claim Submission: Patient Residence

As of January 1, 2022, providers will be required to input an applicable “Patient Residence” code (NCPDP Field 384-4X) in order to be reimbursed for the additional in-home incentive fee(s). The applicable “Patient Residence” codes are as follows:

- 1 – Home
 - Note:** Providers should use Patient Residence code = 1 for temporary housing
- 4 – Assisted Living
- 5 – Custodial Care
- 6 – Group Home
- 14 – Homeless Shelter

Note: For historical claims submitted to Medi-Cal Rx with a DOS **prior** to January 1, 2022, providers must either use an applicable “Place of Service” code (NCPDP Field 307-C7) or “Patient Residence” code (NCPDP Field 384-4X) in order to be reimbursed for the additional in-home incentive fee(s). The applicable “Place of Service” codes are as follows:

- 04 – Homeless Shelter
- 12 – Home
- 13 – Assisted Living Facility
- 14 – Group Home
- 16 – Temporary Lodging
- 33 – Custodial Care Facility

Claim Submission: NDC Billing Policy

Pharmacy providers must submit a claim using the NDC “99999999995” (COVID-19 in the Home Supplemental Administration Rate) to be reimbursed for the in-home incentive fee.

NDC	Label_Name Generic_Name	Maximum Claim Quantity
99999999995	COVID-19 in the Home Supplemental Administration Rate	1

Table 17.2-1: COVID-19 Home Supplemental Administrative Rate and Maximum Claim Quantity

17.3 COVID-19 Antigen Test Kits

The U.S. Department of Health and Human Services (HHS) issued the [Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap](#) on February 9, 2023, stating that the federal COVID-19 PHE ended on May 11, 2023. Emergency Use Authorization (EUA) FDA-authorized, self-administered COVID-19 antigen test kits, to detect proteins called antigens from SARS-CoV-2, the virus that causes COVID-19, will continue to remain a Medi-Cal Rx covered pharmacy benefit, subject to utilization controls and BOP prescription billing requirements.

Background

California State Plan Amendment (SPA) 22-004 required the Medi-Cal program to cover home tests, self-administered antigen test kits. Test kits can be dispensed from a pharmacy, written (or electronic equivalent) on a prescription, signed by a licensed prescriber or a pharmacist. Test kits are limited to 4 tests per member per month (or 2 test kits that include 2 separate tests) where the limit can be exceeded with an approved PA request showing medical necessity.

Coverage for this benefit, directed by SPA 22-0044, was specific for the period starting March 11, 2021, and ending on September 30, 2024.

Policy Effective on and after October 1, 2024

Medi-Cal Rx covers specific EUA FDA-authorized, self-administered COVID-19 antigen tests to detect proteins called antigens from SARS-CoV-2. Covered Medi-Cal Rx tests are listed in the [List of Contracted COVID-19 Antigen Tests](#), which can be found on the [Forms & Information](#) page of the [Medi-Cal Rx Provider Portal](#).

The following criteria apply for coverage of these tests as a Medi-Cal Rx pharmacy benefit:

- Claims for members with or without COVID-19 within the first seven days of symptom onset, exposure from asymptomatic individuals, or other reason to suspect COVID-19; **AND**
 - Refer to the [Medi-Cal Rx Diagnosis Crosswalk](#) to identify accepted diagnosis or ICD-10-CM code(s) to meet the Code I diagnosis restriction for this product.
 - Refer to the [List of Contracted COVID-19 Antigen Tests](#) for age restrictions.
- Prescriptions for contracted tests to detect proteins called antigens from SARS-CoV-2 must be written (or be an electronic equivalent) and signed by a licensed prescriber or a pharmacist and require dispensing from a Medi-Cal Rx pharmacy provider; **AND**
 - Medical supplies prescription requirements apply to these outpatient pharmacy disposable medical supplies with the exception that a licensed pharmacist can also prescribe these tests. Refer to [Section 13.0 – Medical Supplies](#) for additional information.
- Pharmacy providers are required to have one-on-one documented contact (in-person, telehealth, or phone) with the member or caregiver prior to dispensing COVID-19 EUA tests; **AND**

- The member/caregiver must request the pharmacy provider dispense the COVID-19 EUA tests; autofill is not permitted. Items dispensed without a valid documented request will be denied as not reasonable or necessary and are subject to post-adjudication audit review by DHCS; **AND**
- Packages/kits cannot be broken or sold as individual tests; **AND**
- Quantities are restricted to up to 4 tests total (2 kits for 2 tests/kit or 4 single-test kits), currently on the [List of Contracted COVID-19 Antigen Tests](#), per 30 days, per member; **AND**
- Only 1 test-per-kit, or 2 tests-per-kit billing codes (11-digit NDC-like number) are reimbursable, and kits cannot be broken and must be dispensed whole; **AND**
- No refills allowed; the member would need to obtain a new prescription for each dispensing.

Note: PA requests for quantities outside the allowed amounts will be denied unless ordered or administered by a pharmacy provider following an individualized clinical assessment with appropriate medical necessity demonstrated.

Outpatient disposable medical supplies are a partial Medi-Cal carve-out and products not listed in the *Medi-Cal Rx Provider Manual* may be a covered medical benefit through the member's medical coverage, which includes non-listed EUA FDA-authorized, self-administered COVID-19 antigen tests. Managed care members should contact their individual plan for more information.

Polymerase Chain Reaction (PCR) tests for diagnosis of current infection with SARS-CoV-2 are not a Medi-Cal Rx pharmacy benefit; they are a covered Medi-Cal medical benefit and billable through the member's medical coverage. PCR tests, which are more likely to detect the virus than antigen tests, will usually be taken by a healthcare provider in a clinic setting and transported to a laboratory for testing. It may take several days to receive results. Members should contact their medical benefits plan for information about PCR testing.

Refer to the [CDC](#) website for current COVID-19 testing information and guidelines.

17.3.1 COVID-19 Antigen Test Kits Reimbursement

Reimbursement of the contracted EUA FDA-authorized, self-administered COVID-19 antigen tests is based upon the published Maximum Allowable Product Cost (MAPC) plus a 23 percent markup. The MAPC is guaranteed only for purchasing and dispensing to Medi-Cal Rx outpatient members. The adjustment for the 10 percent provider payment reduction per AB 97 (Chapter 3, Statutes of 2011), effective June 1, 2011, does *not* apply to these claims.

Effective October 1, 2024, providers can bill up to 4 tests per dispensing every 30 days, per member, and are required to have one-on-one documented contact with the Medi-Cal member or caregiver who is requesting the test. Providers filling a prescription for a test without a member- or caregiver-initiated request is prohibited (refer to [Section 17.3 – COVID-19 Antigen Test Kits](#) for specific requirements). Coverage is restricted to a contracted *List*, and fill frequencies and quantity limitations apply (refer to [Section 17.3 – COVID-19 Antigen Test Kits](#) for those limitations).

Providers shall not submit claims for items obtained at no cost, and Upper Billing Limits apply. Refer to [Section 4.6.13 – Medical Supply Reimbursement](#) for additional information.

Coverage policy for EUA FDA-authorized, self-administered COVID-19 antigen tests through Medi-Cal was effective March 11, 2021, through September 30, 2024, under the American Rescue Plan Act (ARPA) of 2021. Reimbursement was limited to 8 tests (4 kits for 2 tests/kit) per 30 days per member during the ARPA time period.

17.4 COVID-19 Oral Antiviral Product Coverage

17.4.1 Paxlovid

Paxlovid (nirmatrelvir tablets and ritonavir tablets) [was approved by the FDA on May 25, 2023](#), for the treatment of mild-to-moderate COVID-19 in adults with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death. In addition, the FDA issued an EUA to make Paxlovid available for the treatment of mild-to-moderate COVID-19 in adults and children 12 years of age and older, weighing at least 88 lb (40 kg), who are at high risk for progression to severe COVID-19, including hospitalization or death. It is given within five days of symptom onset.

The initial supply of oral antivirals has been purchased and provided by the federal government and distributed to pharmacy providers for free. Coverage will apply to members under Medi-Cal Rx, CCS, and GHPP. The drug name, dosage, and strength/package size are outlined in the [CDLs](#) on the [Medi-Cal Rx Web Portal](#).

Paxlovid may be prescribed for a member by a state-licensed pharmacist under the conditions of the EUA and the eligibility standards specified in the FDA's [Fact Sheet for Healthcare Providers](#). Additionally, pharmacists may independently initiate and furnish Paxlovid in accordance with the California BOP's [Order Waiving Restrictions on Pharmacists Independently Initiating and Furnishing Paxlovid to Individual Patients](#).

17.4.1.1 Commercial Paxlovid

On October 13, 2023, Pfizer, the manufacturer of Paxlovid, reached an agreement with the federal government on a timeline to transition Paxlovid from government-managed distribution to traditional commercial distribution. The commercial transition began on November 1, 2023.

Commercial Paxlovid is a Medi-Cal Rx pharmacy benefit for members 12 years of age and older, with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death.

17.4.2 Remdesivir (Veklury)

DHCS no longer requires a PA request for the reimbursement of Remdesivir (Veklury) as a pharmacy benefit. Veklury is an antiviral drug that has been approved by the FDA for the treatment of adults and pediatric patients (28 days of age and older and weighing at least 6 lb, 3 oz [3 kg] with positive results of SARS-CoV-2 viral testing. Veklury is for people who are

hospitalized or not hospitalized with mild-to-moderate COVID-19 symptoms and are at high risk for progression to severe COVID-19, including hospitalization or death. For non-hospitalized patients, Veklury is restricted to a maximum of three days' supply per dispensing for each diagnosis, and treatment must be initiated as soon as possible after diagnosis of COVID-19, within seven days of symptom onset. Documentation is required justifying medical necessity for a longer treatment duration. The drug name, dosage, and strength/package size are outlined in the [CDLs](#) on the [Medi-Cal Rx Web Portal](#).

OHC edits remain applicable to COVID-19 oral antiviral claims (refer to [Section 10.0 – Coordination of Benefits \(COB\)](#) and corresponding subsections for additional information).

17.4.3 Lagevrio

Lagevrio (molnupiravir) is for the treatment of mild-to-moderate COVID-19 in adults (18 years of age and older) with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death, and alternative COVID-19 treatment options approved or authorized by FDA are not accessible or clinically appropriate. It is given within five days of symptom onset. Lagevrio may only be prescribed for an individual member by physicians, advanced practice registered nurses, and physician assistants with the ability to prescribe the medication under specific circumstances specified in the FDA's [Fact Sheet for Healthcare Providers: Emergency Use Authorization for Lagevrio™ \(molnupiravir\) Capsules](#).

17.4.3.1 Commercial Lagevrio

Effective November 1 2023, Lagevrio (molnupiravir) commercial products are available for purchase through commercial channels. The commercial product is not supplied free by the federal government.

Commercial Lagevrio is a Medi-Cal Rx pharmacy benefit for members 18 years of age and older, with positive results of direct SARS-CoV-2 viral testing, and who are at high risk for progression to severe COVID-19, including hospitalization or death, in cases where alternative COVID-19 treatment options approved or authorized by the FDA are not accessible or clinically appropriate.

17.4.4 Pempgarda™ (pemivibart)

The FDA issued an [Emergency Use Authorization of Pempgarda™ \(pemivibart\)](#) for the pre-exposure prophylaxis of COVID-19 in certain adults and adolescents (12 years of age and older weighing at least 88 lb [40 kg]) who are moderately or severely immunocompromised and are unlikely to mount an adequate immune response to the COVID-19 vaccination. Pre-exposure prophylaxis helps prevent COVID-19 but does not take the place of vaccination in people who are eligible to receive an updated COVID-19 vaccine.

Pemgarda (pemivibart) is available to Medi-Cal Rx members as a pharmacy benefit, contingent upon an approved PA request when medically necessary.

Antibody	Concentration	Package Size	NDC
Pemivibart	500 mg/4 ml vial (125 mg/ml)	4 ml vial	81960003103

The product can be obtained through Cardinal Health, Cencora, McKesson Plasma and Biologics, or McKesson Specialty Care Distribution.

17.4.5 COVID-19 Oral Antiviral Products Reimbursement

Reimbursement for COVID-19 oral antiviral products that are federally supplied is outlined as follows:

- No ingredient cost will be paid at this time.
 - Reimbursement logic will apply \$0.00 ingredient cost.
- A professional dispensing fee will be paid at this time.
 - Reimbursement logic will apply a \$13.20 or \$10.05 professional dispensing fee based upon the pharmacy's total (both Medicaid and non-Medicaid) annual claim volume (refer to [Section 4.6.2 – Professional Dispensing Fee](#) for additional information).

17.4.5.1 Paxlovid Reimbursement for Pharmacist Services

Medical Claims (for information only): Claims for the consultation and assessment must be billed to DHCS (CA-MMIS) on a medical claim as a Pharmacist Service using CPT codes 99202 (new patient) and 99212 (existing patient) and reimbursed with the current methodology for pharmacist services found in the [DHCS Provider Manual](#).

- Claims billed with CPT codes 99202 and 99212 must be submitted on a CMS-1500 medical claim form.
- Eligible claims must have an ICD-10-CM diagnosis code, U07.1 (COVID-19).
- DHCS is making a temporary allowance to allow billing with these CPT codes effective immediately through the end of the coverage mandated under ARPA which ends on September 30, 2024.

17.4.6 Commercial COVID-19 Oral Antiviral Products Reimbursement

Effective November 1, 2023, reimbursement for the new commercial COVID-19 oral antiviral products is as follows:

- The ingredient cost plus a professional dispensing fee will be paid at this time.
 - Reimbursement logic will apply a \$13.20 or \$10.05 professional dispensing fee based upon the pharmacy's total (both Medicaid and non-Medicaid) annual claim volume (refer to [Section 4.6.2 – Professional Dispensing Fee](#) for additional information).

18.0 Mpox Vaccine Coverage

JYNNEOS is approved by the FDA for subcutaneous injection for the prevention of mpox virus infection in individuals 18 years of age and older who are at high risk for mpox infection. Effective for claims with a DOS from August 17, 2022, through January 31, 2023, during the PHE, Medi-Cal Rx will reimburse the administration of the mpox vaccine as a pharmacy benefit when administered in accordance with FDA approval or EUA and recommendations from the CDC. The administration fee during this period is at the enhanced Medicare rate.

- For vaccine(s) provided by the federal government, coverage will apply to members under Medi-Cal Rx, Family PACT, CCS, and GHPP. Billable NDCs and maximum quantities are outlined in *Table 18.0-1*.

NDC	Label_Name Generic_Name	Max. Quantity	Max. Claim Quantity
50632000101	JYNNEOS 0.5 ml Vial (Stockpile) Smallpox and Mpox Vaccine	0.5 ml (Subcutaneous), or 0.1 ml (Intradermal)	0.5 ml

Table 18.0-1: Mpox Vaccine Billable NDCs and Maximum Quantity Limits

Effective for claims with a DOS from February 1, 2023, through March 31, 2024, DHCS will no longer reimburse the administration of mpox vaccines based on the enhanced Medicare rate approved by the federal government since the mpox PHE has ended. Effective for claims with a DOS on or after February 1, 2023, DHCS will no longer reimburse the administration of mpox vaccines for the Family PACT Program. This date range includes submission for NDCs 50632000101 and 50632000102.

Effective for claims with a DOS on or after April 1, 2024, the commercial JYNNEOS vaccine (identified by carton NDC 50632000103 and inner pack NDC 50632000101) is a covered Medi-Cal Rx benefit and a VFC-funded vaccine.

In addition, claims submitted to Medi-Cal Rx for the government-supplied JYNNEOS vaccine (NDC 50632000102) will continue to be reimbursed only for the administration fee. The ingredient cost will not be reimbursed.

Note: NDC 50632000101 is an inner pack NDC without a price on file and will reject with Reject Code 85 – Claim Not Processed. Pharmacies may either submit a paper claim, making sure to include the “outer” NDC in the remarks area of the claim form or submit the claim with the outer pack NDC 50632000103. For more information about how to submit a paper claim, refer to [Section 4.4.1 – Missing Price](#).

Note: Claims submitted by VFC-enrolled providers for the VFC-funded vaccine when administered to eligible Medi-Cal members will not be reimbursed for the ingredient cost.

- An SCC is required for submission on incoming claims for mpox vaccines in order to document which dose is being administered.
 - SCC 2 – Other Override should be used to identify the initial dose of the vaccine.
 - SCC 6 – Starter Dose should be used to identify the second dose of the vaccine.
- For paper claims (UCF or 30-1), pharmacy providers are directed to populate the fill number based on the dose:
 - 0 to indicate the first dose.
 - 1 to indicate the second dose.
- OHC edits will remain applicable to mpox vaccine claims (refer to [Section 10.0 – Coordination of Benefits \(COB\)](#)) and corresponding subsections for additional information).
- A supplemental warning message will be sent notifying providers of early administration of mpox vaccine administration.

18.1 >>Mpox Vaccine Reimbursement

For pharmacy claims with a DOS on or after April 1, 2024, reimbursement for mpox vaccines is dependent on provider enrollment in the VFC program and member age as outlined below:

Claims submitted by VFC-enrolled providers for the VFC-funded vaccine will be reimbursed according to the VFC program when administered to Medi-Cal members 18 years of age. Refer to [Section 15.9.1 – Vaccines For Children Program](#).

Claims submitted by VFC- and non-VFC-enrolled pharmacy providers for the VFC-funded vaccine when administered to Medi-Cal members 19 years of age and older will be reimbursed as outlined below:

- Ingredient cost (refer to [Section 4.6.1 – Legend and Non-Legend Drugs](#) for reimbursement information)
- Professional dispensing fee (refer to [Section 4.6.2 – Professional Dispensing Fee](#) for additional information):
 - Reimbursement logic will apply a \$13.20 or \$10.05 professional dispensing fee based on the pharmacy's total (both Medicaid and non-Medicaid) annual claim volume.
- Administration fee:
 - >>DHCS will reimburse for mpox vaccine administration at the lesser of the billed amount or \$15.95. To receive the professional services administration fee, the pharmacy provider must identify that the pharmacy is administering the vaccine and enter the applicable values in the following NCPDP fields:
 - Enter the dollar amount of the administration fee in the Incentive Fee Amount Submitted field (NCPDP Field ID: 438-E3).
 - Select the following Reason for Service Code (NCPDP Field ID: 439-E4):
 - PH = Preventive Health Care
 - Select the following Professional Service Code (NCPDP Field ID: 440-E5):
 - MA = Medication Administration

- Select the following Result of Service Code (NCPDP Field ID: 441-E6):
 - 3N = Medication Administration
- **Note:** If any or all of these fields are left incomplete or blank, claims will continue to adjudicate, but pharmacy providers will not be reimbursed for the professional services administration fee.

Claims submitted by Non-VFC pharmacies for members 18 years of age and younger will deny with Reject Code 60 – Product/Service Not Covered For Patient Age with the supplemental message *"Product only available through a Vaccines for Children (VFC) provider. To locate an eligible provider, see <https://eziz.org/> or call 1-877-243-8832. Age requirement not met. Prior Authorization Required."*

- >>**For retroactive pharmacy claims with a DOS on or after January 1, 2024, through March 31, 2024**, DHCS will reimburse pharmacy providers for mpox vaccine administration at the lesser of the billed amount or \$15.95.
- >>**For retroactive pharmacy claims with a DOS on or after February 1, 2023, through December 31, 2023**, DHCS will reimburse pharmacy providers for mpox vaccine administration at the lesser of the billed amount or \$3.79.
- >>**For retroactive pharmacy claims with a DOS on or after August 17, 2022, through January 31, 2023**, DHCS will reimburse pharmacy providers for mpox vaccine administration at the lesser of the billed amount or at the corresponding Medicare rate of \$17.

>>**Note:** Retroactive claims will not be reimbursed for ingredient cost or professional dispensing fee.

18.2 Mpox Treatment Drugs

For dates of service on or after August 17, 2022, DHCS will reimburse the dispensing of mpox treatment drug, Tecovirimat (TPOXX) as a pharmacy benefit when this is in accordance with the provisions of the FDA-regulated Expanded Access Investigational New Drug (EA-IND) protocol and the CDC's guidance.

TPOXX is an antiviral drug that is FDA-approved for the treatment of smallpox in adults and pediatric patients. Its use for treatment of mpox is permitted by EA-IND protocol through the CDC. A PA is not required and there is no minimum age required for this treatment.

Pharmacy providers may bill for the dispensing of TPOXX NDCs using NCPDP D.0 claims, web, batch, and paper claims according to the following table:

NDC	Label_Name Generic_Name	Claim Quantity	Max. Quantity
50072001030	TPOXX Tecovirimat	20 ml (200 mg/20 ml in SDV)	42 vials
50072020042	TPOXX Tecovirimat	42 capsules (Each bottle contains 42 × 200 mg capsules)	126 capsules

Table 18.2-1: TPOXX Billable NDCs, Billing Quantity, and Maximum Quantity

Product Availability:

- TPOXX is available from the U.S. Strategic National Stockpile (SNS). It can be ordered from CDPH and does not need to go through CDC.
- Clinicians and care facility pharmacists requesting TPOXX should contact their [local health department](#) for current local availability. Pre-positioned supply may be the fastest route to obtain TPOXX.
- The local health department Medical Health Operational Area Coordinator (MHOAC) will submit a resource request to CDPH and medications will be shipped to the healthcare facility.
- CDC can assist in the diagnosis and management of patients with suspected mpox. If treatment drugs are needed, or additional information is required, providers should contact the CDC Emergency Operations Center at 1-770-488-7100, Monday through Friday 8:00 a.m. to 4:30 p.m. ET; at other times call 1-404-639-2888.

18.2.1 Adult Dosages

Mpox (off-label use):

- I.V.
 - 35 to <120 kg: 200 mg every 12 hours (CDC 2022a)
 - ≥120 kg: 300 mg every 12 hours (CDC 2022a)
- Oral
 - 40 to <120 kg: 600 mg every 12 hours (CDC 2022a)
 - ≥120 kg: 600 mg every 8 hours (CDC 2022a)

Duration of therapy: 14 days; duration may be longer (up to 90 days) or shorter depending on disease progression and clinical condition of the patient (CDC 2022a). Data on duration other than 14 days are limited.

18.2.2 Pediatric Dosages

Mpox (off-label use):

- Oral
 - **Note:** The smallest capsule size is 200 mg; doses lower than 200 mg require manipulation of capsule, increasing risk for dose inaccuracy. Use caution; before use, ensure caregivers are able to prepare as directed (CDC 2022a).
 - Infants, Children, and Adolescents (CDC 2022a):
 - <6 kg: 50 mg every 12 hours
 - 6 to <13 kg: 100 mg every 12 hours
 - 13 to <25 kg: 200 mg every 12 hours
 - 25 to <40 kg: 400 mg every 12 hours
 - 40 to <120 kg: 600 mg every 12 hours
 - ≥120 kg: 600 mg every 8 hours

- I.V.
 - **Note:** Use I.V. formulation with caution in patients less than 2 years of age due to limited experience with hydroxypropyl-B-cyclodextrin excipient.
 - Infants, Children, and Adolescents (CDC 2022a):
 - <35 kg: 6 mg/kg/dose every 12 hours
 - 35 to <120 kg: 200 mg every 12 hours
 - ≥120 kg: 300 mg every 12 hours

19.0 Claim Forms

When completing and submitting the forms in the following subcategories, use the legibility and completion standards below:

Legibility and Completion Standards

- Submitting Forms: Submit the form to the Medi-Cal Rx vendor and retain a copy for your records. Clarity is necessary for proper scanning.
- Unacceptable Forms: Carbon copies, photocopies, computer-generated form facsimiles, or forms created on laser printers are not acceptable for the forms mentioned in this section.
- Pin-Fed Forms: Remove all perforated sides and separate each individual form. For accurate scanning, leave a ¼-inch border on the left and right side of the form after removing the perforated sides.
- Do Not Fold or Crease: To expedite the sorting and preparation of claims for scanning, do not fold or crease forms to fit into small-sized envelopes. Enclose forms in full-sized envelopes.

Typed and Handwritten Forms:

- Type all information (using capital letters) on forms whenever possible for clarity and accuracy using 10-point font or larger (not to exceed the size of the field). Do not use script or italic font.
- Handwritten forms should be printed neatly and accurately using a ballpoint pen only. Do not use red pencils or red ink ballpoint pens. All requirements pertaining to typed forms, such as entering data within the text space, apply to handwritten forms.
- Printer Ribbons: Use black film-type or high-quality ribbons. Ribbons should be changed regularly to ensure that a clear, distinct character is printed. Frequently change the ink cartridges in the printer to avoid light ink. Blurred or light printing may be misread by the scanning equipment. Avoid printing claim forms using a dot matrix printer. Laser printers are strongly recommended.
- Type in Designated Areas Only: Type only in areas of the form designated as fields. Be sure the data falls completely within the text space and is properly aligned. Many of the forms have Elite and Pica alignment boxes.
- Do not type in shaded areas, or areas labeled "FOR F.I. USE ONLY." These areas are reserved for use by the Medi-Cal Rx vendor only.

- Alpha or Numeric Characters: Use only alphabetical letters or numbers in data entry fields. Do not type zeros with a dot in the center. The scanning equipment may misread dotted zeroes.
- No Highlighting Pens: Never highlight information. When the form attachments are scanned on arrival by the Medi-Cal Rx vendor, the highlighted area will show up only as a black mark, obscuring the highlighted information.

Provider Signature

Medi-Cal Rx requires providers or their designees to sign and date all claim forms, PA requests, CIFs, or appeals. An original signature is required on all forms. The signature must be written, not printed. Stamps, initials, or facsimiles are not acceptable. When signing, use a ballpoint pen.

Corrections

Do not strike through errors or use correction tape or fluids.

Attachments

Attached documentation for claims, CIFs, or appeals should clearly reference the field name that requires additional documentation. The claim field name on the attachment should be legible, underlined, or circled in black ballpoint pen. Allow adequate line space between each claim field number description.

- Carbon copies of documents are not acceptable. Instead, make a photocopy of the original.
- **Note:** Do not highlight or use tape to fasten attachments to the claim form. Do not use original claims as attachments since they may be interpreted as original claims.

19.1 Universal Claim Form, Version D.0

The *Universal Claim Form* (UCF) is used by providers who wish to submit a paper pharmacy (non-compound or compound) claim. The UCF may be purchased from NCPDP's vendor, CommuniForm LLC, or ordered by phone, fax, or online. [Appendix B – Directory](#) at the end of this manual provides the source for obtaining UCFs and the Medi-Cal Rx vendor address and fax number that pharmacies should use to mail or fax UCF submissions. Refer to *Figure 19.1-1* for a sample UCF.

Note: If submitting a *Charpentier* or *Crossover Claim* on a UCF, these **must** be identified by writing **Charpentier** or **Crossover** on the form.


INSURANCE	1-ID: _____ 2-Group ID: _____		 NCPDP UNIVERSAL CLAIM FORM (UCF) Version 1.1 – 05/2009 © 2008-2009, 2010. All rights reserved.																														
	3-Last: _____ 4-First: _____																																
PATIENT	5-Plan Name: _____		6-BIN Number: _____ 7-Processor Control Number: _____																														
	8-Last: _____ 9-First: _____ 10-Person Code: _____		11-D.O.B: _____ mm dd cyy 12-Gender: _____ 13-Relationship: _____																														
PHARMACY	15-Service Provider ID: _____ 16-Qualifier: _____		17-Name: _____ 18-Tel #: _____																														
	19-Address: _____ 20-City: _____ 21-State: _____ 22-Zip: _____		SIGNATURE OF PROVIDER (I certify that the statements on the reverse apply to this bill and are made a part thereof.) 23-(Signed) _____ 24-(Date) _____																														
LABORATORY	25-ID: _____ 26-Qualifier: _____		27-Last Name: _____ 28-ID: _____ 29-Qualifier: _____																														
	<table border="1"> <tr> <td>30-Prescription/Service Ref. #</td> <td>31-Qual</td> <td>32-Fill #</td> <td>33-Data Written mm dd cyy</td> <td>34-Date Of Service mm dd cyy</td> <td>35-Submission Clarification</td> <td>36-Prescription Origin</td> </tr> <tr> <td>37-Product/Service ID</td> <td>38-Qual</td> <td colspan="3">39-Product Description</td> <td>40-Quantity Dispensed</td> <td>41-Days/42-DAW Supply Code</td> </tr> <tr> <td>43-Prior Auth # Submitted</td> <td>44-PA Type</td> <td>45-Other Coverage</td> <td>46-Delay Reason</td> <td>47-Level Of Service</td> <td colspan="2">48-Place Of Service</td> </tr> <tr> <td>49-Diagnosis Code</td> <td>50-Qual</td> <td>DUR</td> <td colspan="2">DUR / PPS CODES 51-Reason/52-Service/53-Result</td> <td>54-Level of Effort</td> <td>55-Procedure Modifier</td> </tr> </table>				30-Prescription/Service Ref. #	31-Qual	32-Fill #	33-Data Written mm dd cyy	34-Date Of Service mm dd cyy	35-Submission Clarification	36-Prescription Origin	37-Product/Service ID	38-Qual	39-Product Description			40-Quantity Dispensed	41-Days/42-DAW Supply Code	43-Prior Auth # Submitted	44-PA Type	45-Other Coverage	46-Delay Reason	47-Level Of Service	48-Place Of Service		49-Diagnosis Code	50-Qual	DUR	DUR / PPS CODES 51-Reason/52-Service/53-Result		54-Level of Effort	55-Procedure Modifier	
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CLAIM	56-Other Payer ID		57-Qual	58-Other Payer Date mm dd cyy	59-Other Payer Rejects	60-Other Payer ID	61-Qual	62-Other Payer Date mm dd cyy	63-Other Payer Rejects																								
	64-Dosage Form Description Code		65-Dispensing Unit Form Indicator		66-Route of Administration		67-Ingredient Component Count																										
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Copyright 2008, 2009, 2010																																	

Figure 19.1-1: Universal Claim Form (UCF), Version D.0

19.1.1 >>Completion Instructions for the UCF

The following item numbers and descriptions in *Table 19.1.1-1* below correspond to *Figure 19.1-1 Universal Claim Form (UCF), Version D.0* above. **All items must be completed unless otherwise specified in these instructions.**

Item	Description
Insurance	
1	ID. Enter the member's Medi-Cal ID, CIN, or HAP ID as it appears on the Identification Card.
2	Group ID. Enter the Group ID (MEDI-CAL RX)
3	Last. Enter the last name as it appears on the Identification Card.
4	First. Enter the first name as it appears on the Identification Card.

Item	Description
5	Plan Name. Enter the Plan Name (MEDI-CAL RX)
6	BIN Number. Enter the BIN Number (022659)
7	Processor Control Number (PCN). Enter the PCN (6334225)
Patient	
8	Last. Enter the last name of the member.
9	First. Enter the first name of the member.
10	Person Code. Not a required field.
11	D.O.B. (Date of Birth). Enter the member's DOB in MMDDYYYY format. Obtain this information from the member's BIC ID. Note: This information <i>must</i> be entered for the claim to process successfully.
12	Gender. Use the capital letter "M" for male, "F" for female, or "U" for Unknown.
13	Relationship. If billing for a newborn using the mother's Medi-Cal ID, a Relationship Code = 03 – Dependent must be entered, otherwise LEAVE BLANK.
14	For Office Use Only (Document Control Number). LEAVE BLANK.
Pharmacy	
15	Service Provider ID. Enter the pharmacy NPI number. This information must be entered for the claim to successfully process.
16	Qualifier. Identifies the NCPDP D.0 standard provider ID type. The only ID qualifier allowed is "01 – NPI."
17	Name. Enter the pharmacy name.
18	Tel. #. Enter the pharmacy telephone number (to include the area code)
19	Address. Enter the pharmacy address.
20	City. Enter the city for the pharmacy.
21	State. Enter the state for the pharmacy.
22	Zip. Enter the pharmacy's nine-digit ZIP code. Note: The nine-digit ZIP code entered in this field must match the biller's ZIP code on file for claims to be reimbursed correctly.
23	Signature of Provider. The pharmacist must sign in this field.
24	Date. Enter the date the pharmacist signed the form.

Item	Description
Prescriber	
25	ID. Enter the NPI number of the prescriber or, if applicable, the NPI number of the certified nurse-midwife, nurse practitioner, physician's assistant, neuropathic doctor, or pharmacist who functions pursuant to a policy, procedure, or protocol as required by Bus & Prof Code statutes. Do not use the Drug Enforcement Administration Narcotic Registry Number. This information must be entered for the claim to process successfully.
26	>>Service Provider ID Qualifier. Identifies the NCPDP D.0 standard provider ID type. Enter the only ID qualifier allowed, "01 – NPI."
27	Last Name. Enter the last name of the Prescriber.
Pharmacist	
28	ID. Not a required field.
29	Qualifier. Not a required field.
Claim	
30	Prescription/Service Ref. #. Enter the prescription number in this space for reference on the RA.
31	>>Prescription Reference Number Qualifier. Enter '01" for Rx billing.
32	Fill#. Enter a refill number. 00 = Original Dispensing – The first dispensing 01-99 = Refill Number – Number of the replenishment.
33	Date Written. Enter the date the prescription was written.
34	Date of Service. Enter the date the prescription was filled in 8-digit MMDDYYYY format. Example: August 6, 2007 = 08_06_2007
35	Submission Clarification. Enter an SCC if applicable, otherwise LEAVE BLANK. Note: Up to three SCCs are allowed.
36	Prescription Origin. Enter the method in which the prescription was received. Example: 0 – Not Specified, 1 – Written, 2 – Telephone, 3 – Electronic, 4 – Fascimile (Fax), 5 – Pharmacy.

Item	Description												
37	Product/Service ID. Enter the 11-digit NDC for the product being submitted.												
	Zero Fill NDC Numbers												
	All NDC numbers <i>must</i> be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into 3 segments. For a complete 11-digit number, the first segment <i>must</i> have 5 digits, the second segment 4 digits, and the third segment 2 digits. Add leading 0s wherever they are needed to complete a segment with the correct number of digits.												
	Examples:												
	<table><tr><td><u>Package Number</u></td><td><u>Zero Fill</u></td><td><u>11-digit NDC</u></td></tr><tr><td>1234-1234-12</td><td>(01234-1234-12)</td><td>01234123412</td></tr><tr><td>12345-123-12</td><td>(12345-0123-12)</td><td>12345012312</td></tr><tr><td>2-22-2</td><td>(00002-0022-02)</td><td>00002002202</td></tr></table>	<u>Package Number</u>	<u>Zero Fill</u>	<u>11-digit NDC</u>	1234-1234-12	(01234-1234-12)	01234123412	12345-123-12	(12345-0123-12)	12345012312	2-22-2	(00002-0022-02)	00002002202
	<u>Package Number</u>	<u>Zero Fill</u>	<u>11-digit NDC</u>										
	1234-1234-12	(01234-1234-12)	01234123412										
12345-123-12	(12345-0123-12)	12345012312											
2-22-2	(00002-0022-02)	00002002202											
Drug Manufacturer and Product Codes													
If the item being billed is a drug, refer to the CDL (found on the Medi-Cal Rx Provider Portal by selecting Forms & Information and then Covered Products Lists) for information on authorized drug manufacturer labeler codes. The products of manufacturers not listed in the CDL are not covered by Medi-Cal without authorization.													
38	Medical Supplies												
	Medical supplies that may be billed as “pharmacy only” benefits according to NCPDP claim transaction standards include diabetic supplies, peak flow meters, inhalers, contraceptive products, and enteral nutrition formula (refer to Section 12.0 – Enteral Nutrition Products and Section 13.0 – Medical Supplies for additional information).												
39	>>Product/Service ID Qualifier. Enter “03” – NDC.												
40	Product Description. Enter the name of the drug/product being submitted.												
41	Quantity Dispensed. Enter the quantity dispensed.												
42	Days Supply. Enter the estimated number of days that the drug dispensed will last.												
42	DAW Code. If applicable (if not applicable LEAVE BLANK), enter one of the below values. For more information on DAW codes, refer to Section 15.5 – Dispense As Written (DAW) Codes .												
	<table><tr><th>Code</th><th>Description</th></tr><tr><td>0</td><td>No Product Selection Indicated</td></tr><tr><td>1</td><td>Substitution Not Allowed by Prescriber</td></tr><tr><td>2</td><td>Substitution Allowed – Patient Requested Product Dispensed</td></tr><tr><td>3</td><td>Substitution Allowed – Pharmacist Selected Product Dispensed</td></tr></table>	Code	Description	0	No Product Selection Indicated	1	Substitution Not Allowed by Prescriber	2	Substitution Allowed – Patient Requested Product Dispensed	3	Substitution Allowed – Pharmacist Selected Product Dispensed		
	Code	Description											
	0	No Product Selection Indicated											
	1	Substitution Not Allowed by Prescriber											
	2	Substitution Allowed – Patient Requested Product Dispensed											
	3	Substitution Allowed – Pharmacist Selected Product Dispensed											

Item	Description	
	4	Substitution Allowed – Generic Drug Not In Stock
	5	Substitution Allowed – Brand Drug Dispensed as a Generic
	6	Override
	7	Substitution Not Allowed – Brand Drug Mandated by Law
	8	Substitution Allowed – Generic Drug Not Available in Marketplace
	9	Substitution Allowed by Prescriber but Plan Requests Brand
43	Prior Auth # Submitted. Required if utilizing Field 44 – PA Type (see below), otherwise LEAVE BLANK.	
44	>>Prior Authorization Type Code. LEAVE BLANK, unless the below option is relevant to the claim being submitted. >>Submit "8" (Payer Defined Exemption) for newborns using the mother's Medi-Cal ID. For additional information on newborn claims refer to Section 8.2.2 – Newborns .	
45	Other Coverage. A valid OCC is required. Enter one of the following values:	
	Code	Description
	0	Not Specified
	1	No Other Coverage Exists
	2	Other Coverage Exists, Payment Collected
	3	Other Coverage Exists, Claim Not Covered
	4	Other Coverage Exists, Payment Not Collected
46	Delay Reason. If there is an exception to the 6-month billing limitation, enter the appropriate reason code number and include the required documentation. For additional information, refer to Section 19.3.1 – Submission and Timeliness Instructions .	
	Code	Description
	1	(1) Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable (2) For SOC reimbursement processing
	2	(1) OHC, including Medicare, Kaiser, CHAMPUS, and other health insurance (2) Charpentier rebill claims
	3	Authorization delays in PA approval
	4	Delay by DHCS in certifying providers or by Medi-Cal Rx vendor in supplying billing forms

Item	Description	
	5	Delay in delivery of custom-made eye, prosthetic, or orthotic appliances
	6	Substantial damage by fire, flood, or disaster to provider records
	7	Theft, sabotage, or other willful acts by an employee Note: Negligence by an employee is <u>not</u> covered by this reason code
	10	(1) Court order, State, or administrative fair hearing decision (2) Delay or error in the certification or determination of Medi-Cal eligibility (3) Update of a PA beyond the 12-month limit (4) Circumstances beyond the provider’s control as determined by DHCS
	A	Claim submitted after the 6-month billing limit and received by Medi-Cal Rx during the 7 th – 12 th month after the month of service and none of the exceptions above applied
	Field Left Blank	Not Specified *
47	Level of Service. Enter “3” – Emergency when submitting an emergency claim, otherwise LEAVE BLANK.	
48	Place of Service. (Patient Residence) If the member is an LTC resident, enter the appropriate Patient Residence code in this field from the options below. If the recipient is not residing in any of these facilities, leave this field blank. 3 – Nursing Facility 9 – Intermediate Care	
Clinical		
49	Diagnosis Code. Enter only if diagnosis code is required for claim submission, otherwise LEAVE BLANK.	
50	>> Diagnosis Code Qualifier. Enter “02” – ICD-10-CM only if a diagnosis code was entered in Field 49, otherwise LEAVE BLANK.	
DUR		
51	DUR/PPS Codes – Reason. Enter appropriate DUR Reason Code (refer to Section 16.0 – Drug Use Review (DUR) for applicable values) when needed to communicate DUR information, otherwise LEAVE BLANK.	
52	DUR/PPS Codes – Service. Enter appropriate DUR Service Code (refer to Section 16.0 – Drug Use Review (DUR) for applicable values) when needed to communicate DUR information, otherwise LEAVE BLANK.	

Item	Description	
53	DUR/PPS Codes – Result. Enter appropriate DUR Result of Service Code (refer to Section 16.0 – Drug Use Review (DUR) for applicable values) when needed to communicate DUR information, otherwise LEAVE BLANK.	
54	Level of Effort. Enter appropriate DUR Level of Effort (refer to Section 16.0 – Drug Use Review (DUR) for applicable values) when needed to communicate DUR information, otherwise LEAVE BLANK. Note: This field is used for compound claims.	
55	Procedure Modifier. Not a required field.	
COB (If member does not have OHC, leave these fields BLANK)		
COB 1		
56	Other Payer ID. Enter the Payer ID of the member’s OHC, if applicable. Otherwise, LEAVE BLANK.	
57	>>Other Payer ID Qualifier. Enter the Other Payer ID Qualifier of the member’s OHC, if applicable. Otherwise, LEAVE BLANK.	
	Code	Description
	01	Standard Unique Health Plan Identifier
	02	Health Industry Number (HIN)
	03	Bank Information Number (BIN)
	04	National Association of Insurance Commissioners
	05	Medicare Carrier Number
	09	Coupon
	99	Other
58	Other Payer Date. Enter if identification of the Other Payer Date is necessary for claim adjudication. Otherwise, LEAVE BLANK.	
59	Other Payer Rejects. Enter the NCPDP Reject Code when the other payer has denied the payment for the billing, designated with OCC = 3 – Other Coverage Exists – Claim Not Covered.	
COB 2		
60	Other Payer ID. Enter the Payer ID of the member’s OHC, if applicable. Otherwise, LEAVE BLANK.	
61	>>Other Payer ID Qualifier. Enter the Other Payer ID Qualifier of the member’s OHC, if applicable. Otherwise, LEAVE BLANK.	
	Code	Description
	01	Standard Unique Health Plan Identifier

Item	Description	
	02	Health Industry Number (HIN)
	03	Bank Information Number (BIN)
	04	National Association of Insurance Commissioners
	05	Medicare Carrier Number
	09	Coupon
	99	Other
62	Other Payer Date. Enter if identification of the Other Payer Date is necessary for claim adjudication. Otherwise, LEAVE BLANK.	
63	Other Payer Rejects. Enter the reject code when the other payer has denied the payment for the billing, designated with OCC = 3 – Other Coverage Exists – Claim Not Covered.	
Compound (If not submitting a compound, leave these fields BLANK)		
64	Dosage Form Description Code. Enter the appropriate code to indicate the dosage form of the finished compound.	
	Code	Description
	01	Capsule
	02	Ointment
	03	Cream
	04	Suppository
	05	Powder
	06	Emulsion
	07	Liquid
	10	Tablet
	11	Solution
	12	Suspension
	13	Lotion
	14	Shampoo
	15	Elixir
	16	Syrup
	17	Lozenge
	18	Enema

Item	Description	
	<p>Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly. Refer to Section 4.6.7.3 – Compounding Fee Breakdown by Dosage Form for additional information.</p>	
65	<p>Dispensing Unit Form Indicator. Enter the appropriate code to indicate the way that the finished compound is measure.</p>	
	Code	Description
	1	Each
	2	Grams (GM)
	3	Milliliters (ML)
66	<p>Route of Administration. The SNOMED must be entered in this section.</p> <p>Note: Compounding fees are paid based upon the dosage form and route of administration (SNOMED value) information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.</p>	
	Route of Administration	SNOMED Value
	Buccal	54417007 or 372473007
	Dental	372449004
	Enteral	417985001
	Infusion	424494006, C44364, or 418114005
	Inhalation	112239003
	Injection	424109004, 385218009, 34206005, or 78421000
	Intraperitoneal	38239002
	I.V.	4625008
	Irrigation	47056001
	Mouth/Throat	26643006 or 26643008
	Mucous Membrane	419874009
	Nasal	46713006
	Ophthalmic	54485002
	Oral	26643006 or 26643008
	Otic	10547007
	Rectal	37161004

Item	Description	
	Vaginal	16857009
	Topical	6064005
	Transdermal	45890007
	Translingual	404815008
	Urethral	90028008
67	Ingredient Component Count. Enter the total compound ingredient components. Note: Medi-Cal supports up to 24 compound product IDs and 1 for the container count (25 Product IDs if a container count is included).	
68	Product Name. Enter the name of the final compounded drug/product.	
69	Product ID. For a compound claim, enter a single zero (0) in the Product ID field and list each ingredient name, NDC, quantity, and cost in the appropriate fields in the "Compound" section of the form.	
70	>>Product/Service ID Qualifier. Enter "00" – Not Specified.	
71	Ingredient Qty. Enter the total quantity per ingredient in the compound.	
72	Ingredient Drug Cost. Enter the ingredient drug cost per ingredient in the compound.	
73	Basis of Cost. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.	
	Code	Description
	01	AWP (Average Wholesale Price)
	02	Local Wholesalers
	03	Direct
	04	EAC (Estimated Acquisition Cost)
	05	Acquisition
	06	MAC (Maximum Allowable Cost)
	07	Usual & Customary (U&C)
	08	340B/Disproportionate Share Pricing/Public Health Service
	Field Left Blank	Not Specified
Pricing (Format (1,234.56))		
74	Usual & Customary Charge. Enter the U&C charge being submitted for the claim.	

Item	Description	
75	Basis of Cost Determination. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.	
	Code	Description
	01	AWP (Average Wholesale Price)
	02	Local Wholesalers
	03	Direct
	04	EAC (Estimated Acquisition Cost)
	05	Acquisition
	06	MAC (Maximum Allowable Cost)
	07	Usual & Customary (U&C)
	08	340B/Disproportionate Share Pricing/Public Health Service
Field Left Blank	Not Specified	
76	Ingredient Cost Submitted. Enter the Ingredient Cost being submitted for the claim.	
77	Dispensing Fee Submitted. Enter the Dispensing Fee being submitted for the claim. Note: Only required to be entered if its value has an effect on the GAD calculation.	
78	Prof Service Fee Submitted. Required if claim being submitted is a PAD, otherwise LEAVE BLANK.	
79	Incentive Amount Submitted. Enter the Incentive Amount being submitted for the claim. (Used to indicate Compound Sterilization Fee).	
80	Other Amount Submitted. Used to indicate Compounding Fee. Refer to Section 4.6.7.3 – Compounding Fee Breakdown by Dosage Form for additional information.	
81	Sales Tax Submitted. LEAVE BLANK.	
82	Gross Amount Due (Submitted). Enter the GAD submitted for the claim.	
83	Patient Paid Amount. LEAVE BLANK.	
84	Other Payer Amount Paid #1. Enter the value that the other payer has approved for payment for some/all of the billing.	
85	Other Payer Amount Paid #2. Enter the value that the other payer has approved for payment for some/all of the billing.	
86	Other Payer Patient Resp. Amount #1. Enter the amount the member paid as part of the primary insurance claim.	

Item	Description
87	Other Payer Patient Resp. Amount #2. Enter the amount the member paid as part of the primary insurance claim.
88	Net Amount Due. Enter the GAD – Other Payer Patient Resp. Amount #1 (Field 86) and Other Payer Patient Resp. Amount #2 (Field 87).

Table 19.1.1-1: Universal Claim Form (UCF), Version D.0 Completion Instructions

19.2 California Specific Claim Forms (30-1) and (30-4)

19.2.1 California Specific Pharmacy Claim Form (30-1)

The *California Specific Pharmacy Claim Form* (30-1) is used by pharmacies to bill Medi-Cal Rx for paper claim submission(s). The form is available for download or printing on the [Medi-Cal Rx Provider Portal](#) under the [Forms & Information](#) link. [Appendix B – Directory](#) at the end of this manual provides the Medi-Cal Rx vendor address and fax number that pharmacies should use to mail or fax *California Specific Pharmacy Claim Form* (30-1) submissions. Refer to *Figure 19.2-1* for a sample *California Specific Pharmacy Claim Form* (30-1).

Note: If billing for a Compound, the UCF or the *California Specific Compound Pharmacy Claim Form* (30-4) must be used.

Crossover pharmacy claims that *do not cross over automatically* via NCPDP must be billed on the UCF (refer to [Section 19.1 – Universal Claim Form, Version D.0](#)) or the *California Specific Pharmacy Claim Form* (30-1).

DO NOT
STAPLE IN
BAR AREA

CLAIM CONTROL NUMBER * FOR F.I. USE ONLY
1

Fasten
Here
9

PHARMACY CLAIM FORM

Provider Name, Address
3A

2 ID QUALIFIER 3 PROVIDER ID
2
3

4 ZIP CODE
4

STATE OF CALIFORNIA
 DEPARTMENT OF HEALTH
 CARE SERVICES

Provider Phone Number:

ELITE PICA

TYPEWRITER ALIGNMENT

ELITE PICA

PATIENT INFORMATION		MEDI-CAL IDENTIFICATION NO		SEX	DATE OF BIRTH	PATIENT LOCATION	MEDICARE STATUS
5 PATIENT NAME (LAST, FIRST, MI)		6		7	8 MM DD YYYY	9	10

11 PRESCRIPTION NO	12 FILL NUMBER	13 DATE OF SERVICE	14 METRIC QUANTITY	15 CODE 1 MET?	16 EMERGENCY FILL?	17 DAYS SUPPLY
11	12	13 MM DD YYYY	14 WHOLE UNITS DECIMAL	15 Y	16 Y	17
18 BASIS OF COST DETERMINATION	19 PROD ID QUAL	20 PRODUCT ID	21 ID QUAL	22 PRESCRIBER ID		
18	19	20	21	22		
23 PRIMARY ICD-CM	24 SECONDARY ICD-CM	25 CHARGE	26 OTHER COVERAGE PAID	27 OTH COV CODE		
23	24	25	26	27		
28 PATIENT'S SHARE	29 TAR CONTROL NO	30 COMP CODE	31 DELETE			
28	29	30	31 Y			

32 PRESCRIPTION NO	33 FILL NUMBER	34 DATE OF SERVICE	35 METRIC QUANTITY	36 CODE 1 MET?	37 EMERGENCY FILL?	38 DAYS SUPPLY
32	33	34 MM DD YYYY	35 WHOLE UNITS DECIMAL	36 Y	37 Y	38
39 BASIS OF COST DETERMINATION	40 PROD ID QUAL	41 PRODUCT ID	42 ID QUAL	43 PRESCRIBER ID		
39	40	41	42	43		
44 PRIMARY ICD-CM	45 SECONDARY ICD-CM	46 CHARGE	47 OTHER COVERAGE PAID	48 OTH COV CODE		
44	45	46	47	48		
49 PATIENT'S SHARE	50 TAR CONTROL NO	51 COMP CODE	52 DELETE			
49	50	51	52 Y			

53 PRESCRIPTION NO	54 FILL NUMBER	55 DATE OF SERVICE	56 METRIC QUANTITY	57 CODE 1 MET?	58 EMERGENCY FILL?	59 DAYS SUPPLY
53	54	55 MM DD YYYY	56 WHOLE UNITS DECIMAL	57 Y	58 Y	59
60 BASIS OF COST DETERMINATION	61 PROD ID QUAL	62 PRODUCT ID	63 ID QUAL	64 PRESCRIBER ID		
60	61	62	63	64		
65 PRIMARY ICD-CM	66 SECONDARY ICD-CM	67 CHARGE	68 OTHER COVERAGE PAID	69 OTH COV CODE		
65	66	67	68	69		
70 PATIENT'S SHARE	71 TAR CONTROL NO	72 COMP CODE	73 DELETE			
70	71	72	73 Y			

SPECIFIC DETAILS/REMARKS:
82

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on the back of this form.

81 Signature of provider or person authorized by provider to bind provider by above signature to statements and conditions contained on this form
81

74 MEDICAL RECORD NO	75 BILL NUMBER	76 ATTACHMENTS
74	75	76
77 DATE BILLED	78 DISCHARGE DATE	79 F.I. USE ONLY
77 MM DD YYYY	78 MM DD YYYY	79
77	78	79

30-1 01/18

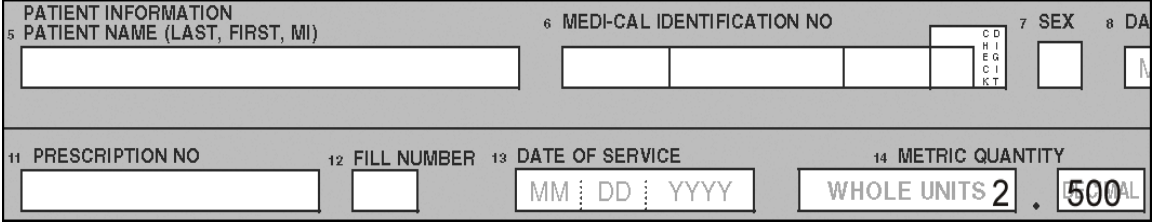
Figure 19.2-1: California Specific Pharmacy Claim Form (30-1)

19.2.1.1 Completion Instructions for California Specific Pharmacy Claim Form (30-1)

The following item numbers and descriptions in *Table 19.2.1.1-1* below correspond to *Figure 19.2-1 California Specific Pharmacy Claim Form (30-1)* above. **All items must be completed *unless otherwise specified in these instructions*.**

Item	Description
1	Document Control Number. For Medi-Cal Rx vendor use only. <i>Do NOT</i> mark in this area. A unique 14-digit number, assigned by the Claims Team to track each claim, will be entered here when the claim is received by the Medi-Cal Rx vendor.
2	ID Qualifier. Identifies the NCPDP D.0 standard provider ID type. The only ID qualifier allowed is "01 – NPI."
3	Provider ID. Enter your NPI number. Do <i>not</i> submit claims using a Medicare provider number or State license number.
3a	Provider Name, Address, Phone Number. Enter your name, address, and telephone number. Confirm the information entered is correct <i>before</i> submitting claim forms.
4	Zip Code. Enter the pharmacy's nine-digit ZIP code. Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.
5	Patient Name. Enter the member's last name, first name and middle initial, if known. Avoid nicknames or aliases.
	Newborn Infant
	If submitting a claim for a newborn infant using the mother's Medi-Cal ID number, enter the infant's name, sex, and DOB. If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl." Infants from a multiple birth must also be designated by number or letter (for example, "Twin A"). Write "Newborn infant using mother's card, Patient Relationship Code = 3, and PATC = 8" in the Specific Details/Remarks field. Note: Services to an infant may be billed with the mother's Medi-Cal ID for the month of birth and the following month only , after which the infant must have their own Medi-Cal Rx ID number.
6	Medi-Cal Identification Number. Enter the member's Medi-Cal ID, CIN, HAP, or BIC as it appears on the Identification Card.
7	Sex. Use the capital letter "M" for male, "F" for female or "U" for Unknown. (For newborns, refer to <i>Item 5 – Newborn Infant</i> .)

Item	Description
8	<p>Date of Birth. Enter the member's DOB in MMDDYYYY format. Obtain this information from the member's BIC ID.</p> <p>Note: This information <i>must</i> be entered for the claim to process successfully.</p>
9	<p>Patient Location. If the member is an LTC resident, enter the appropriate Patient Residence code in this field from the options below. If the recipient is not residing in any of these facilities, leave this field blank.</p> <p>3 – Nursing Facility</p> <p>9 – Intermediate Care</p>
10	<p>Medicare Status. Medicare Status Codes (listed below) are required for Charpentier claims. In all other circumstances, these codes are optional.</p> <p>Note: All codes except for "0" and "8" require documentation.</p> <p>0 – Under 65, does not have Medicare Coverage</p> <p>1 – Benefits Exhausted</p> <p>2 – Utilization committee denial or physician noncertification</p> <p>3 – No prior hospital stays</p> <p>4 – Facility Denial</p> <p>5 – Noneligible provider</p> <p>6 – Noneligible member</p> <p>7 – Medicare benefits denied or cut short by Medicare intermediary</p> <p>8 – Noncovered services</p> <p>9 – PSRO denial</p> <p>L – Medi/Medi Charpentier: Benefit Limitations</p> <p>R – Medi-Medi Charpentier: Rates</p> <p>T – Medi/Medi Charpentier: Both rates and benefit limitations</p> <p>Note: * – Documentation required. Refer to the Section 10.4.2 – Charpentier Claims and Section 19.3.3 – Tips for Billing Charpentier Claims for additional information.</p>
11	<p>Prescription Number. Enter the prescription number in this space for reference on the RA (paper check and voucher).</p>
12	<p>Fill Number. Enter a refill number</p> <p>0 or 00 = Original Dispensing – The first dispensing</p> <p>1-99 = Refill Number – Number of the replenishment</p>
13	<p>Date of Service. Enter the date that the prescription was filled in 8-digit MMDDYYYY format.</p> <p>Example: August 6, 2007 = 08062007</p>

Item	Description
14	<p>Metric Quantity. The quantity dispensed must be submitted in metric decimal form. <u>A decimal is pre-imprinted on the claim form.</u> Do not include a decimal in either of the boxes of the <i>Metric Quantity</i> field or the claim will be returned.</p> <p>Example: A quantity of 2.5 must be submitted with the number '2' in the "Whole Units" box and the '5' in the "Decimal" box. The "Decimal" field must include trailing zeros, for a total of three characters. Do <i>not</i> include measurement units such as GM, CC, or ML.</p>  <p>Use Correct Measurement Unit</p> <p>The correct measurement unit is listed beside each item in the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information and then Covered Products Lists). This is the measurement unit to be used for billing. For items requiring a PA, the approved authorization will specify the exact units to be used in the quantity field of the claim form.</p> <p>Package Size Specific Codes</p> <p>Items in the CDL are sometimes package-size specific. In such cases, use the code that corresponds to a trade package made by the manufacturer whose product is dispensed. If the manufacturer does not make a trade package containing the quantity dispensed, use the code that corresponds to the package size that was used in filling the prescription.</p> <p>Example: If 60 grams of an ointment are dispensed out of a 454-gram jar, the code for the 454-gram jar should be used.</p> <p>Prepacks</p> <p>The units (GMs, MLs, or Each) that are to be used when billing the program, are specified in the item's listing. The units specified must be used in all cases. The quantity entered for prepacks should always be in the number of units specified in the CDL.</p>
15	<p>Code I (Restrictions) Met? Enter "Y" if the Code I restriction(s) listed in the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information and then Covered Products Lists) has been met; otherwise enter "N" or leave blank.</p>

Item	Description	
16	Emergency Fill? If the drug was dispensed in an emergency, use indicator "Y" for 'yes' or "N" for 'no,' or leave blank.	
17	Days Supply. Enter the estimated number of days that the drug dispensed will last.	
18	Basis of Cost Determination. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.	
	Code	Description
	01	AWP (Average Wholesale Price)
	02	Local Wholesalers
	03	Direct
	04	EAC (Estimated Acquisition Cost)
	05	Acquisition
	06	MAC (Maximum Allowable Cost)
	07	Usual & Customary (U&C)
	08	340B/Disproportionate Share Pricing/Public Health Service
	<i>Field left blank</i>	Not Specified
19	Product ID Qualifier. This field identifies the type of Product ID submitted. Place a '03' for NDC.	
20	Product ID. When billing for drugs, enter the 11-digit NDC.	
	Zero Fill NDC Numbers	
	All NDC numbers <i>must</i> be 11 digits long. NDCs printed on packages often have fewer than 11 digits, with hyphens (-) separating the number into 3 segments. For a complete 11-digit number, the first segment <i>must</i> have 5 digits, the second segment 4 digits, and the third segment 2 digits. Add leading 0's wherever they are needed to complete a segment with the correct number of digits.	
	Examples:	
	<u>Package Number</u>	<u>Zero Fill</u> <u>11-digit NDC</u>
	1234-1234-12	(01234-1234-12) 01234123412
	12345-123-12	(12345-0123-12) 12345012312
	2-22-2	(00002-0022-02) 00002002202
	Drug Manufacturer and Product Codes	
	If the item being billed is a drug, refer to the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information and then Covered	

Item	Description
	<p>Products Lists) for information on authorized drug manufacturer labeler codes. The products of manufacturers not listed in the CDL are not covered by Medi-Cal without authorization.</p> <p>Medical Supplies</p> <p>Medical supplies that may be billed as “pharmacy only” benefits according to NCPDP claim transaction standards include diabetic supplies, peak flow meters, inhalers, contraceptive products, and enteral nutrition formula (refer to Section 12.0 – Enteral Nutrition Products and Section 13.0 – Medical Supplies for additional information).</p>
21	<p>Prescriber ID Qualifier. Identifies the NCPDP D.0 standard provider ID type. The only ID qualifier allowed is “01 – NPI.”</p>
22	<p>Prescriber ID. Enter the NPI number of the prescriber or, if applicable, the NPI number of the certified nurse-midwife, nurse practitioner, physician assistant, naturopathic doctor or pharmacist who functions pursuant to a policy, procedure, or protocol as required by Bus & Prof Code statutes. Do not use the DEA Narcotic Registry Number. This information must be entered for your claim to successfully process</p>
23	<p>Primary ICD-CM. Optional. If available, enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including the fourth through seventh digits, if present. Do not enter the decimal point.</p> <p>Important: For claims with DOS or dates of discharge <i>on or after</i> October 1, 2015, enter the ICD indicator “0” as an additional digit before the ICD-10-CM code. The ICD indicator is required only if a primary diagnosis code is being entered on the claim. Secondary diagnosis codes do not require the indicator. Claims that contain a primary diagnosis code, but no ICD indicator may be denied.</p>
24	<p>Secondary ICD-CM. Optional. The primary diagnosis code should be placed in the first occurrence and the secondary should be placed in the second occurrence.</p>
25	<p>Charge. Enter the dollar and cents amount for this item. <u>Do not</u> enter a decimal point (.) or dollar sign (\$).</p>
26	<p>Other Coverage Paid. Optional item, unless OHC payment was received. Enter the full dollar amount of payment received from OHC carriers. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. If the OHC payment received is a negative value, enter zero (0) in this field and enter a “2” in the <i>Other Coverage Code</i> field (Box 27). For NCPDP hardcopy pharmacy crossovers, add the Other Health Coverage Amount(s) and Medicare Paid Amount, enter the combined total.</p>

Item	Description
27	Other Coverage Code. A valid OCC is required. Enter one of the following values: 0 – Not Specified 1 – No Other Coverage Exists 2 – Other Coverage Exists, Payment Collected 3 – Other Coverage Exists, Claim not covered 4 – Other Coverage Exists, Payment Not Collected
28	Patient's Share (of Cost). N/A for Medi-Cal Rx (leave blank). For more information, refer to Section 9.3 – Share of Cost (SOC) .
29	TAR Control Number. N/A LEAVE BLANK (Not used by Medi-Cal Rx vendor)
30	Compound Code. Enter the appropriate code in this box. 0 – Not specified 1 – Not a Compound Note: Compound pharmacy claims must be billed on the UCF or the <i>Compound Pharmacy Claim Form</i> (30-4), through the POS network, or electronically through the WCS on the Medi-Cal Rx Provider Portal .
31	Delete. If an error has been made, enter an "X" in this space to delete the entire line. Enter the correct billing information on another line. When a <i>Delete</i> box is marked "X," the information on the line will be "ignored" by the system and will not be entered as a claim line.
32-73	Additional Claim Lines. Lines 2 and 3 are used for additional items for the <i>same patient</i> during the <i>same month of service</i> .
74	Medical Record Number. Optional – for provider use only.
75	Billing Limit Exceptions. If there is an exception to the 6-month billing limitation, enter the appropriate reason code number and include the required documentation. Refer to Section 19.3.1 – Submission and Timeliness Instructions .
76	Attachments. Enter an "X" if attachments are included with the claim Example: Catalog pages, invoices, etc. Leave blank if not applicable. Reminder: If this box is not marked, attachments may not be seen by the claim examiner, which may cause the claim to be denied.
77	Date Billed. Enter the date this statement is being submitted to the Medi-Cal Rx vendor (use MMDDYYYY format).
78	Discharge Date. Leave blank. This will be used for the date the patient was discharged from the hospital.
79-80	Medi-Cal Rx vendor USE ONLY. Leave blank.

Item	Description
81	<p>Signature of Provider and Date. The claim must be signed and dated by the provider or a representative assigned by the provider. Use BLACK ballpoint pen only.</p> <p>Note: An <u>original</u> signature is required on all paper claims. The signature <i>must be written</i>, not printed. Stamps, initials, or facsimiles are not acceptable. The signature does not have to be on file with the Medi-Cal Rx vendor.</p>
82	<p>Specific Details/Remarks. Use this blank space to clarify or detail any line item. <u>Indicate the line-item number being referenced.</u> If additional space is needed, insert a capital "X" or "Y" in <i>Box 76 (Attachments)</i> and clip or staple your attachment to the top right-hand corner of the claim.</p> <p>The <i>Specific Details/Remarks</i> area is also used to provide information on Crossovers or Charpentier Rebilling. Refer to Section 19.2.1.2 – (30-1): Tips for Billing for more information.</p>
	<p style="text-align: center;">Emergency Certification Statement</p> <p>Beginning January 1, 2022, emergency claims can be billed via POS, Web-Claim Submission/Direct Data Entry, or paper claim. For emergency claims submitted via paper form(s), they must include an Emergency Certification Statement.</p> <p>The Emergency Certification Statement must be attached to the claim and include:</p> <ul style="list-style-type: none"> • The nature of the emergency, including relevant clinical information about the patient's condition • Why the emergency services rendered were considered to be immediately necessary • The signature of the physician, podiatrist, dentist, or pharmacist who had direct knowledge of the emergency <p>The statement must be comprehensive enough to support a finding that an emergency existed. A mere statement that an emergency existed is not sufficient.</p> <p>An Emergency Certification Statement may not be used in place of a PA for contracted diabetic testing supplies that require authorization when the maximum quantity has been reached.</p>

**Table 19.2.1.1-1: California Specific Pharmacy Claim Form (30-1)
Completion Instructions**

For the *Metric Quantity* field on the (30-1) Form, a decimal point and the trailing zeros *must* be present.

- **Example:** A quantity of '4' must be submitted as '4.000' (the field must include the trailing zeros). A quantity of '100' should be billed as '100.000.'

For the *Dollar Amount* fields, do not fill in the decimal point. The cents should still be included in the amount.

- **Example:** \$10.00 should appear as '1000' in the dollar amount field(s).

For the *Other Health Coverage Code* (OTH COV CODE) fields, if the member has OHC, enter the appropriate code.

- **Note:** Put '0 – Not Specified or No Other Health Coverage Exists' if the member does not have OHC or leave the field blank.

19.2.1.2 (30-1) Tips for Billing

This section contains *Table 19.2.1.2-1*, which details the *California Specific Pharmacy Claim Form* (30-1) fields that must be completed accurately and completely in order to avoid claim denial.

Common Billing Errors		
Field	Description	Error
Upper Left Corner	Provider Name, Address, Phone Number	Not entering the provider phone number on claim form. Billing Tip: Enter provider telephone number with area code. (This is optional, but helpful if there is a need to contact the provider.)
Box 14	Metric Quantity	Quantities must include the decimal point and trailing zeros. <ul style="list-style-type: none"> • Example: The quantity for two 3.5 gm tubes would be 7.000 using metric decimals. An individual tube would be 3.500. Note: Providers must bill the metric decimal quantity to three decimal places. Rounding may cause the claim to pay the incorrect dollar amount and may cause the claim to be denied. <u>Billing Units:</u> <ul style="list-style-type: none"> • Each: Solid oral dosage forms (tablet/capsule), powder filled (dry) vials, packets, patches, etc. • Milliliter (ml): Liquid oral dosage forms, liquid filled vials, ampules, reconstituted oral products, etc. • Grams (gm): Ointments, bulk powders (not I.V.), etc.

Common Billing Errors		
Field	Description	Error
Box <u>18</u>	Basis of Cost Determination	<p>Entering "00" – Not Specified when the drug dispensed was not purchased under the 340B Drug Discount Program.</p> <p>Billing Tip: Any provider purchasing drugs through the 340B program <u>must</u> pass the discounted ingredient cost to Medi-Cal. A "<u>08</u>" in this field means the ingredient cost was purchased with a 340B Drug Discount Program contract.</p>
Box <u>20</u>	Product ID	Do not use hyphens when entering the NDC numbers in this field.
Box <u>25</u>	Charge	<p>Entering the incorrect billing amount.</p> <p>Billing Tip: Bill full Usual And Customary (U&C) charges, or class of trade price including tax. Do <i>not</i> include the decimal in this box. The amount entered should include cents.</p>
Box <u>26</u>	Other Coverage Paid	<ul style="list-style-type: none"> Entering no charges when the Other Coverage Code box contains "2" indicating other coverage payment was collected. Entering charges in this field when the Other Coverage Code box does <i>not</i> contain "2." <p>Billing Tip: Enter the amount of payment received from OHC carriers. Leave blank if not applicable. Do <i>not</i> include the decimal in this box. The amount entered should include cents.</p>
Box <u>27</u>	Other Coverage Code	<ul style="list-style-type: none"> Not including a valid code or using a code other than "2" with an amount in the Other Coverage Paid box. Entering a 'Y,' indicating YES (not an acceptable code) <p>Billing Tip: Valid Codes:</p> <p>0 – Not Specified</p> <p>1 – No Other Coverage Exists</p> <p>2 – Other Coverage Exists, Payment Collected</p> <p>3 – Other Coverage Exists, Claim not covered</p> <p>4 – Other Coverage Exists, Payment Not Collected</p>

Common Billing Errors		
Field	Description	Error
		Provider must be able to readily retrieve proof of claim submission and payment if collected from the other payer(s). The provider is certifying that the other health insurance was billed.
Box 29	TAR Control Number	N/A. LEAVE BLANK (not used by Medi-Cal Rx vendor)
Box 76	Attachments	Not including attachment with the claim. Billing Tip: Do not mark this box if attachments are <i>not</i> included with the claim.
Common Attachment Reminders	Catalog pages/invoices	Tip: Circle in black the item being billed and indicate claim line number. Quantity per package can be written in (must be able to compute one each price). Retail pricing is never acceptable
Box 81	Signature of Provider and Date	Not including a signature on the claim. Billing Tip: Claim <i>must</i> be signed in BLACK ink. Stamps, initials, or facsimiles are not acceptable.
Box 82	Specific Details/Remarks	Information on claim does not match attachment. Billing Tip: Product numbers, NDC numbers, product information in the <i>Specific Details/Remarks</i> area must match the information supplied on the attachment. Specify the claim line number on the attachment.

Table 19.2.1.2-1: California Specific Pharmacy Claim Form (30-1) Tips for Billing

19.2.2 California Specific Compound Pharmacy Claim Form (30-4)

The *California Specific Compound Pharmacy Claim Form* (30-4) is used by pharmacies to bill Medi-Cal Rx for multi-ingredient compound drug prescriptions and single ingredient sterile transfers. The form is available for download or printing on the [Medi-Cal Rx Provider Portal](#) under the [Forms & Information](#) link. [Appendix B – Directory](#) at the end of this manual provides the Medi-Cal Rx vendor address and fax number that pharmacies should use to mail or fax *California Specific Compound Pharmacy Claim Form* (30-4) submissions. Refer to *Figure 19.2.2-1* for a sample *California Specific Compound Pharmacy Claim Form* (30-4).

Ingredients that *do not* have an associated NDC will not be accepted. Attachments providing where an NDC can be located (attached catalog page, invoice, or other supporting documentation) will be allowed.

Note: If billing for a non-compound claim, the UCF, or the *California Specific Pharmacy Claim Form* (30-1) must be used.

Crossover compound pharmacy claims that *do not cross over automatically* via NCPDP *must* be billed on the *California Specific Compound Pharmacy Claim Form (30-4)*. Refer to *Figure 19.2.2-1*. These claims **cannot** be billed via WCS/Direct Data Entry or POS Network.

The form is titled "COMPOUND DRUG PHARMACY CLAIM FORM" and is issued by the "STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES". It includes a "CLAIM CONTROL NUMBER" field at the top, labeled with a circled 1. A large circled 3 is in the top right corner. The form is divided into several sections: "PATIENT INFORMATION" (fields 5-9), "PRESCRIPTION INFORMATION" (fields 10-17), "MEDICARE/MAJOR MEDICARE INFORMATION" (fields 18-25), "TOTAL CHARGE" (fields 26-31), "INGREDIENT PRODUCT ID" (field 32), "INGREDIENT QUANTITY" (fields 33-36), "INGREDIENT CHARGE" (field 37), "BASE OF COST" (field 38), "MEDICAL RECORD NO." (field 39), "BILL UNITS" (field 40), "DATE BILLED" (field 41), "HOSP DISCHARGE DATE" (field 42), "INGREDIENT TOTAL CHARGE" (field 43), "CONTAINER COUNT" (field 44), "F.I. USE ONLY" (field 45), and "SPECIFIC DETAILS/REMARKS" (field 46). A signature line (field 47) and a date field (field 48) are at the bottom. A "DO NOT STAPLE IN THIS AREA" warning is in the top left. A "TYPEWRITER ALIGNMENT" line is in the center. A "Faster Here" logo is in the top right. A "SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM" note is at the bottom left. A "Revision Date: 01/18" and "Form Number: 30-4" are at the bottom right.

Figure 19.2.2-1: California Specific Compound Pharmacy Claim Form (30-4)

19.2.2.1 Completion Instructions for California Specific Compound Pharmacy Claim Form (30-4)

The following item numbers and descriptions in *Table 19.2.2.1-1* below correspond to the *California Specific Compound Pharmacy Claim Form (30-4)* in *Figure 19.2.2-1* above. **All items must be completed unless otherwise specified in these instructions.**

California Specific Compound Pharmacy Claim Form (30-4)	
Item	Description
1	Document Control Number. For Medi-Cal Rx vendor use only. <i>Do NOT</i> mark in this area. A unique 14-digit number, assigned by the Claims Team to track each claim, will be entered here when the claim is received by the Medi-Cal Rx vendor.
2	ID Qualifier. Identifies the NCPDP D.0 standard provider ID type, the only ID qualifier allows is "01 – NPI."
3	Provider ID. Enter your NPI number. Do <i>not</i> submit claims using a Medicare provider number or State license number.
3a	Provider Name, Address, Phone Number. Enter the provider name, address, and telephone number. Confirm this information is correct <i>before</i> submitting the claim form.
4	Zip Code. Enter the pharmacy's nine-digit ZIP code. Note: The nine-digit ZIP code entered in this box must match the biller's ZIP code on file for claims to be reimbursed correctly.
5	Patient Name. Enter the member's last name, first name and middle initial, if known. Avoid nicknames or aliases
	Newborn Infant
	<p>When submitting a claim for a newborn infant using the mothers ID number, enter the infant's name, sex, and year of birth in the appropriate spaces. Enter the complete DOB in the MMDDYYYY format and write "Newborn infant using mother's card, Patient Relationship Code = 3, and PA Type Code = 8" in the Specific Details/Remarks field.</p> <p>If the infant has not yet been named, write the mother's last name followed by "Baby Boy" or "Baby Girl" (Example: Jones, Baby Girl). If newborn infants from a multiple birth are being billed in addition to the mother, each newborn must also be designated by number or letter (Example: Jones, Baby Girl, Twin A).</p> <p>Note: Services to an infant may be billed with the mother's Medi-Cal ID for the month of birth and the following month only. After this time, the infant must have their own Medi-Cal Rx ID number.</p>

California Specific Compound Pharmacy Claim Form (30-4)	
Item	Description
6	Medi-Cal Identification Number. Enter the member's Medi-Cal ID, CIN, HAP, or BIC as it appears on the Identification Card.
7	Sex. Use the capital letter "M" for male, "F" for female or "U" for Unknown. (For newborns, refer to <i>Item 5 – Newborn Infant</i> .)
8	Date of Birth. Enter the member's DOB in MMDDYYYY format. Obtain this information from the member's BIC ID. Note: This information <i>must</i> be entered for the claim to process successfully.
10	Prescription Number. Enter the prescription number in this space for reference on the RA.
11	Fill Number. Enter a refill number 0 or 00 = Original Dispensing – The first dispensing 1-99 = Refill Number – Number of the replenishment
12	Date of Service. Enter the date that the prescription was filled in 8-digit MMDDYYYY format. Example: August 6, 2007 = 08062007
13	Total Metric Quantity. Enter the quantity of the entire amount dispensed and being billed on the claim. Quantities <i>must</i> be in metric decimal format. <u>Do not</u> include a decimal in either of the two fields that make up the metric decimal quantity or the claim <u>will be returned</u> . Do not include measurement descriptors such as "Gm" or "cc." For example: A 2.4 Gm powder will be 2 in the <i>Whole Units</i> box and 4 in the <i>Decimal</i> box and three 2.4cc ampules will be 2.4 x 3 = 7.2 (7 in the <i>Whole Units</i> box and 2 in the <i>Decimal</i> box).
14	Code I (Restrictions) Met? Enter "Y" if the Code I restriction(s) listed in the CDL (which can be found on the Medi-Cal Rx Provider Portal by selecting Forms & Information and then Covered Products Lists) has been met; otherwise enter "N" or leave blank.
15	Emergency Fill? If the drug was dispensed in an emergency, use indicator "Y" for 'yes,' "N" for 'no,' or leave blank
16	Days' Supply. Enter the estimated number of days that the drug dispensed will last.
17	Patient Location. If the member is an LTC resident, enter the appropriate Patient Residence code in this field from the options below. If the recipient is not residing in any of these facilities, leave this field blank. 3 – Nursing Facility 9 – Intermediate Care

California Specific Compound Pharmacy Claim Form (30-4)										
Item	Description									
18	<p>Medicare Status. Medicare status codes are required for Charpentier claims. In all other circumstances, these codes are optional. The Medicare Status codes are:</p> <p>R – Medi/Medi Charpentier: Rates</p> <p>L – Medi/Medi Charpentier: Benefit Limits</p> <p>T – Medi/Medi Charpentier: Both Rates & Benefit Limitations</p> <p>0 – Under 65, does not have Medicare coverage</p> <p>If the member is not Medicare eligible leave Item 18 blank.</p>									
19	<p>Prescriber ID Qualifier. Identifies the type of prescriber ID submitted NPI.</p> <p>Note: Medi-Cal Rx currently accepts <i>only</i> a provider's NPI number. Enter "01" to indicate NPI license number under NCPDP D.0 standards.</p>									
20	<p>Prescriber ID. Enter the NPI, or, if applicable, the NPI number of the certified nurse-midwife, the nurse practitioner, the physicians' assistant, the naturopathic doctor, or the pharmacist who function pursuant to a policy, procedure or protocol as required by Bus & Prof Code statutes. Do <i>not</i> use DEA Narcotic Registry Number. The NPI must be entered for your claim to successfully process.</p>									
21	<p>Primary ICD-CM. Optional. If available, enter all letters and/or numbers of the ICD-10-CM code for the primary diagnosis, including the fourth through seventh digits, if present. Do not enter the decimal point.</p> <p>Important: For claims with dates of service or dates of discharge <i>on or after</i> October 1, 2015, enter the ICD indicator "0" as an additional digit before the ICD-10-CM code.</p> <p>The ICD indicator is required only if a primary diagnosis code is being entered on the claim. Secondary diagnosis codes do not require the indicator. Claims that contain a primary diagnosis code, but no ICD indicator may be denied.</p>									
22	<p>Secondary ICD-CM. Optional item. Refer to <i>Item 21 – Primary ICD-CM</i> for description.</p>									
23	<p>Dosage Form Description Code. Enter the appropriate code to indicate the dosage form of the finished compound.</p> <table border="1"> <thead> <tr> <th>Code</th> <th>Description</th> </tr> </thead> <tbody> <tr> <td>01</td> <td>Capsule</td> </tr> <tr> <td>02</td> <td>Ointment</td> </tr> <tr> <td>03</td> <td>Cream</td> </tr> </tbody> </table>		Code	Description	01	Capsule	02	Ointment	03	Cream
Code	Description									
01	Capsule									
02	Ointment									
03	Cream									

California Specific Compound Pharmacy Claim Form (30-4)		
Item	Description	
	04	Suppository
	05	Powder
	06	Emulsion
	07	Liquid
	10	Tablet
	11	Solution
	12	Suspension
	13	Lotion
	14	Shampoo
	15	Elixir
	16	Syrup
	17	Lozenge
	18	Enema
	Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.	
24	Dispensing Unit Form Indicator. Enter the appropriate code to indicate the way that the finished compound is measured.	
	Code	Description
	1	Each
	2	Grams (GM)
	3	Milliliters (ML)
25	Route of Administration. Leave blank. The Systematized Nomenclature of Medicine (SNOMED)/Route of Administration (ROA) code is required and must be entered in <i>Box 48 – Specific Details/Remarks</i> .	
26	Total Charge. Enter the total dollar and cents amount for the claim. This amount should include all compounding, sterility, and professional fees. For I.V. and intra-arterial injections only, the fees should be multiplied by the number of containers before adding them to the total charge. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). Note: Compounding fees are paid based upon the dosage form and route of administration information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.	

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description										
27	Other Coverage Paid. Optional item, unless OHC payment was received. Enter the full dollar amount of payment received from OHC carriers. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. If the OHC payment received is a negative value, enter zero (0) in this field and enter a "2" in the <i>Other Coverage Code</i> field (Box 28). For NCPDP hardcopy pharmacy crossovers, add the Other Health Coverage Amount(s) and Medicare Paid Amount, enter the combined total.										
28	Other Coverage Code. A valid Other Coverage Code is required. Enter one of the following values: 0 – Not Specified 1 – No Other Coverage Exists 2 – Other Coverage Exists, Payment Collected 3 – Other Coverage Exists, Claim Not Covered 4 – Other Coverage Exists, Payment Not Collected										
29	Patient's Share (of Cost). N/A for Medi-Cal Rx (leave blank). For more information, refer to Section 9.3 – Share of Cost .										
30	Incentive Amount. Optional item. If sterility testing was performed, enter the full dollar amount of the sterility test charge in this field. <u>Do not</u> enter a decimal point (.) or dollar sign (\$). Leave blank if not applicable. For I.V. and intra-arterial injections only, the sterility testing fee should be multiplied by the number of containers.										
31	TAR Control Number. N/A LEAVE BLANK (not used by Medi-Cal Rx vendor)										
32	(Ingredient) Product ID Qualifier. Enter the appropriate code to indicate the type of ingredient that is in Item 33. <table border="1" style="width: 100%; margin-top: 5px;"> <thead> <tr> <th style="text-align: center;">Code</th><th style="text-align: center;">Explanation</th></tr> </thead> <tbody> <tr> <td style="text-align: center;">01</td><td>Universal Product Code (UPC)</td></tr> <tr> <td style="text-align: center;">03</td><td>National Drug Code (NDC)</td></tr> <tr> <td style="text-align: center;">04</td><td>Universal Product Number (UPN)</td></tr> <tr> <td style="text-align: center;">99</td><td>Other</td></tr> </tbody> </table>	Code	Explanation	01	Universal Product Code (UPC)	03	National Drug Code (NDC)	04	Universal Product Number (UPN)	99	Other
Code	Explanation										
01	Universal Product Code (UPC)										
03	National Drug Code (NDC)										
04	Universal Product Number (UPN)										
99	Other										
33	Ingredient Product ID. Indicates the ingredient used in the compound drug. This must be an NDC number.										

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description																				
34	Ingredient Quantity. Enter the total quantity of the ingredient in all containers. Quantities must be in the metric decimal format. The decimal point must not be included in either of the two fields that make up the metric decimal quantity or the claim will be returned. Do not include measurement descriptors such as "GM," "CC," or "ML."																				
35	Ingredient Charge. Enter the dollar and cents amount for this ingredient for all containers in this field. <u>Do not</u> enter a decimal point (.) or dollar sign (\$).																				
36	<p>(Ingredient) Basis of Cost Determination. Enter the appropriate code to indicate the method used to calculate the ingredient cost. If claim was for 340B/Disproportionate Share Pricing/Public Health Service, '08' <u>must</u> be used.</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 5px;"> <thead> <tr style="background-color: #d9d9d9;"> <th style="width: 20%;">Code</th> <th style="width: 80%;">Description</th> </tr> </thead> <tbody> <tr><td style="text-align: center;">01</td><td>AWP (Average Wholesale Price)</td></tr> <tr><td style="text-align: center;">02</td><td>Local Wholesalers</td></tr> <tr><td style="text-align: center;">03</td><td>Direct</td></tr> <tr><td style="text-align: center;">04</td><td>EAC (Estimated Acquisition Cost)</td></tr> <tr><td style="text-align: center;">05</td><td>Acquisition</td></tr> <tr><td style="text-align: center;">06</td><td>MAC (Maximum Allowable Cost)</td></tr> <tr><td style="text-align: center;">07</td><td>Usual & Customary (U&C)</td></tr> <tr><td style="text-align: center;">08</td><td>340B/Disproportionate Share Pricing/Public Health Service</td></tr> <tr><td style="text-align: center;"><i>Field left blank</i></td><td>Not Specified</td></tr> </tbody> </table>	Code	Description	01	AWP (Average Wholesale Price)	02	Local Wholesalers	03	Direct	04	EAC (Estimated Acquisition Cost)	05	Acquisition	06	MAC (Maximum Allowable Cost)	07	Usual & Customary (U&C)	08	340B/Disproportionate Share Pricing/Public Health Service	<i>Field left blank</i>	Not Specified
Code	Description																				
01	AWP (Average Wholesale Price)																				
02	Local Wholesalers																				
03	Direct																				
04	EAC (Estimated Acquisition Cost)																				
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06	MAC (Maximum Allowable Cost)																				
07	Usual & Customary (U&C)																				
08	340B/Disproportionate Share Pricing/Public Health Service																				
<i>Field left blank</i>	Not Specified																				
Multiple Ingredient Lines (1-23)	<p>Multiple Ingredient Lines. List all ingredients in the compounded drug. If blank lines are present between ingredients or ingredient lines are crossed out, the claim will be returned. When billing for more than 23 ingredients, enter the following numbers for the 23rd ingredient:</p> <p>Product ID Qualifier = 99 Product ID = 99999999998 Quantity = total quantity of the additional ingredients on the compound drug attachment Charge = total charge for the additional ingredients on the compound drug attachment</p>																				

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description																		
37	<p>Medical Record Number. Optional item. If a medical record number or account number is assigned to the member field, enter that number to identify the member more easily. A maximum of 10 numbers and/or letters may be used.</p> <p>If unique record-keeping numbers are not assigned to each member, you may enter the member's name.</p>																		
38	<p>Billing Limit Exceptions. If there is an exception to the 6-month billing limitation, enter the appropriate reason code number and include the required documentation.</p> <table border="1" style="width: 100%;"> <thead> <tr> <th style="text-align: center;">Code</th><th style="text-align: center;">Description</th></tr> </thead> <tbody> <tr> <td style="text-align: center;">1</td><td> (1) Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable (2) For SOC reimbursement processing </td></tr> <tr> <td style="text-align: center;">2</td><td> (1) OHC, including Medicare, Kaiser, CHAMPUS, and other health insurance (2) Charpentier rebill claims </td></tr> <tr> <td style="text-align: center;">3</td><td>Authorization delays in PA approval</td></tr> <tr> <td style="text-align: center;">4</td><td>Delay by DHCS in certifying providers or by Medi-Cal Rx vendor in supplying billing forms</td></tr> <tr> <td style="text-align: center;">5</td><td>Delay in delivery of custom-made eye, prosthetic, or orthotic appliances</td></tr> <tr> <td style="text-align: center;">6</td><td>Substantial damage by fire, flood, or disaster to provider records</td></tr> <tr> <td style="text-align: center;">7</td><td> Theft, sabotage, or other willful acts by an employee Note: Negligence by an employee is <u>not</u> covered by this reason code </td></tr> <tr> <td style="text-align: center;">10</td><td> (1) Court order, State, or administrative fair hearing decision (2) Delay or error in the certification or determination of Medi-Cal eligibility (3) Update of a PA beyond the 12-month limit (4) Circumstances beyond the provider's control as determined by DHCS </td></tr> </tbody> </table>	Code	Description	1	(1) Proof of eligibility unknown or unavailable; includes retroactive eligibility or ID cards, if applicable (2) For SOC reimbursement processing	2	(1) OHC, including Medicare, Kaiser, CHAMPUS, and other health insurance (2) Charpentier rebill claims	3	Authorization delays in PA approval	4	Delay by DHCS in certifying providers or by Medi-Cal Rx vendor in supplying billing forms	5	Delay in delivery of custom-made eye, prosthetic, or orthotic appliances	6	Substantial damage by fire, flood, or disaster to provider records	7	Theft, sabotage, or other willful acts by an employee Note: Negligence by an employee is <u>not</u> covered by this reason code	10	(1) Court order, State, or administrative fair hearing decision (2) Delay or error in the certification or determination of Medi-Cal eligibility (3) Update of a PA beyond the 12-month limit (4) Circumstances beyond the provider's control as determined by DHCS
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California Specific Compound Pharmacy Claim Form (30-4)		
Item	Description	
	A	Claim submitted after the 6-month billing limit and received by Medi-Cal Rx during the 7th – 12th month after the month of service and none of the exceptions above applied
	Field Left Blank	Not Specified *
39	Date billed. Enter the date that the prescription will be submitted to the Medi-Cal Rx vendor for processing in 8-digit MMDDYYYY format where "MM" is the 2-digit month, "DD" is the 2-digit day and "YYYY" is the 4-digit year.	
40	Hospital Discharge Date. If needed for compliance with program requirements, enter the date the member was discharged from the hospital in 8-digit MMDDYYYY format where "MM" is the 2-digit month, "DD" is the 2-digit day and "YYYY" is the 4-digit year.	
41	Ingredient Total Charge. Enter the total charge of all the ingredients. <u>Do not</u> enter fees. <u>Do not</u> enter a decimal point (.) or dollar sign (\$).	
42	Process for Approved Ingredients. Optional item. If a "Y" is entered in this field, approved ingredients will be reimbursed, but ingredients not on the Formulary will be paid at \$0.00. If this field is left blank, any ingredient that requires a PA will cause the claim to deny. If the compound contains inexpensive ingredients that would not be worth getting a prior authorization, then the provider may want to use this field to speed the payment of the claim.	
43	Container Count. Enter the member's total number of containers for the compound prescription.	
44	Medi-Cal Rx vendor Leave BLANK	
45	Medi-Cal Rx vendor Use Only Leave BLANK	
46	Medi-Cal Rx vendor Use Only Leave BLANK	
47	<p>Signature of Provider and Date. The claim must be signed and dated by the provider or representative assigned by the provider. Use <u>BLACK</u> ballpoint pen only.</p> <p>An <u>original</u> signature is required on all paper claims. The signature must be written, not printed. Stamps, initials, or facsimiles are not acceptable. The signature does not have to be on file with Medi-Cal Rx.</p>	

California Specific Compound Pharmacy Claim Form (30-4)

Item	Description																																										
48	<p>Specific Details/Remarks Section.</p> <p>The SNOMED/ROA value MUST be included in this section.</p> <p>Note: Compounding fees are paid based upon the dosage form and route of administration (SNOMED value) information submitted on the pharmacy claim. To ensure proper payment, be certain to enter this information correctly.</p> <p>This space can also be used to clarify or detail any line item. <u>Indicate the ingredient line-item number being referenced.</u></p> <p>The <i>Specific Details/Remarks</i> area is also used to provide information about crossovers.</p> <table border="1"> <thead> <tr> <th colspan="2">SNOMED CT – NCPDP Field 995-E2</th></tr> <tr> <th>Route of Administration</th><th>SNOMED Value</th></tr> </thead> <tbody> <tr> <td>Buccal</td><td>54417007 or 372473007</td></tr> <tr> <td>Dental</td><td>372449004</td></tr> <tr> <td>Enteral</td><td>417985001</td></tr> <tr> <td>Infusion</td><td>424494006, C44364, or 418114005</td></tr> <tr> <td>Inhalation</td><td>112239003</td></tr> <tr> <td>Injection</td><td>424109004, 385218009, 34206005, or 78421000</td></tr> <tr> <td>Intraperitoneal</td><td>38239002</td></tr> <tr> <td>I.V.</td><td>4625008</td></tr> <tr> <td>Irrigation</td><td>47050061</td></tr> <tr> <td>Mouth/Throat</td><td>26643006 or 26643008</td></tr> <tr> <td>Mucous Membrane</td><td>419874009</td></tr> <tr> <td>Nasal</td><td>46713006</td></tr> <tr> <td>Ophthalmic</td><td>54485002</td></tr> <tr> <td>Oral</td><td>26643006 or 26643008</td></tr> <tr> <td>Otic</td><td>10547007</td></tr> <tr> <td>Rectal</td><td>37161004</td></tr> <tr> <td>Vaginal</td><td>16857009</td></tr> <tr> <td>Topical</td><td>6064005</td></tr> <tr> <td>Transdermal</td><td>45890007</td></tr> </tbody> </table>	SNOMED CT – NCPDP Field 995-E2		Route of Administration	SNOMED Value	Buccal	54417007 or 372473007	Dental	372449004	Enteral	417985001	Infusion	424494006, C44364, or 418114005	Inhalation	112239003	Injection	424109004, 385218009, 34206005, or 78421000	Intraperitoneal	38239002	I.V.	4625008	Irrigation	47050061	Mouth/Throat	26643006 or 26643008	Mucous Membrane	419874009	Nasal	46713006	Ophthalmic	54485002	Oral	26643006 or 26643008	Otic	10547007	Rectal	37161004	Vaginal	16857009	Topical	6064005	Transdermal	45890007
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California Specific Compound Pharmacy Claim Form (30-4)		
Item	Description	
	Translingual	404815008
	Urethral	90028008
	<p style="text-align: center;">Emergency Certification Statement</p> <p>Beginning January 1, 2022, emergency claims can be billed via POS, Web-Claim Submission/Direct Data Entry, or paper claim. For emergency claims submitted via paper form(s), they must include an Emergency Certification Statement.</p> <p>Note: For information regarding what information is required on the Emergency Certification Statement, refer to the end of Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form (30-1).</p>	

**Table 19.2.2.1-1: California Specific Compound Pharmacy Claim Form (30-4)
Completion Instructions**

19.2.2.2 (30-4) Tips for Billing

The examples in this section are to assist providers in completing the *California Specific Compound Pharmacy Claim Form (30-4)*. Refer to *Table 19.2.2.2-1* for fields that must be completed accurately and completely in order to avoid claim denial. For information on claim fields not detailed in the following examples, refer to [Section 19.2.2.1 - Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#).

Tip: Quantities must be in the metric decimal system. Do not round the quantity. Do not include measurement units (GM, CC, ML). The form has separate fields for the whole number and decimal portions of the quantity fields. Decimal points are not allowed within the fields. The decimal points are preimprinted on the form. All information on an attachment must match the information entered on the claim form.

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Figure 19.2.2.2-1: Compounded I.V. Prescription Example

Common Billing Errors		
Field	Description	Error
Box <u>12</u>	Date of Service	<p>The date of service is entered using the incorrect format.</p> <p>Billing Tip: The date <u>must</u> be entered in an 8-digit MMDDYYYY. For example, August 27, 2007, would be entered 08272007.</p>
Box <u>21</u>	Primary ICD-CM	<p>The Primary ICD-CM code is entered without the ICD indicator.</p> <p>Billing Tip: The ICD indicator is <i>only required</i> if a <i>primary</i> diagnosis code is being entered on the claim. Secondary diagnosis codes do <i>not</i> require the indicator. Claims that contain a primary diagnosis code, but no ICD indicator may be denied.</p>
Box <u>25</u>	Route of Administration	<p>A value was entered in this field.</p> <p>Billing Tip: The Route of Administration field should be left blank. If a value is entered in this field, the claim will be returned.</p> <p>Note: Beginning 04/01/2020, the applicable SNOMED value must be entered in the <i>Specific Details/Remarks</i>. In the example above in <i>Figure 19.3.2-1</i>, Box 23 – <i>Dosage Form Description</i> indicates that this is a solution. It is also shown that Box 24 – Dispensing Unit Form Indicator was completed as a “3,” indicating that the Unit of Measure (UOM) of the compound is milliliters (ml). The compound is to be administered intravenously, so SNOMED value 4625008 would be entered in the <i>Specific Details/Remarks</i> field NOT the Route of Administration field.</p>
Box <u>32</u>	Product ID Qualifiers	<p>Billing Tip: The value entered in this/these field(s) will apply to the associated line. The example above indicates “03” which specifies that NDCs were used.</p>

Common Billing Errors		
Field	Description	Error
Box 34	Ingredient Quantity	<p>If a decimal is entered in either of the two fields that make up the metric decimal quantity, the claim will be returned.</p> <p>Billing Tip: Quantities must be entered in the metric decimal format. Do not include measurement descriptors such as "GM," "CC," or "ML" in this field.</p> <p>Note: The pharmacy will enter the sum total of the Ingredient Product ID for the associated line.</p>
Box 35	Ingredient Charge	<p>Billing Tip: The pharmacy will enter the sum total charge for the corresponding line of the compound ingredient.</p>
Box 41	Ingredient Total Charge	<p>The sum of all ingredient charges <i>and</i> fees is entered in this field.</p> <p>Billing Tip: <u>Do not include fees</u> in this field, only include the sum of all ingredient charges.</p>
Box 42	Process for Approved Ingredients	<p>Billing Tip: If a "Y" was entered in this field, it would mean that if any ingredients having NDCs are <i>not</i> found in the Formulary, or if any ingredients require a PA and no PA is present, those ingredients will be priced at zero (0) and the remainder of the ingredients will be paid. This means that when a "Y" is entered in Box 42, a portion of the ingredients may not be paid and the provider accepts payment for the remainder, rather than having the entire claim denied.</p> <p>Note: Box 42 – <i>Process for Approved Ingredients</i> in the example provided in <i>Figure 19.3.2-1</i> has been left blank.</p>
Box 47	Signature of Provider and Date	<p>Not including a signature on the claim</p> <p>Billing Tip: Claim <i>must</i> be signed in BLACK ink. Stamps, initials, or facsimiles are not acceptable.</p>
	Specific Details/Remarks	<p>Billing Tip: As noted above, the applicable SNOMED value must be entered in this field. If a SNOMED value is not entered for the compound claim, the claim will be returned.</p>

**Table 19.2.2.2-1: California Specific Compound Pharmacy Claim Form (30-4)
Tips for Billing**

19.3 Paper Claim Forms (UCF, (30-1) and (30-4)) Additional Tips

19.3.1 Submission and Timeliness Instructions

This section provides procedures and guidelines for claim submission and timelines. For specific claim completion instructions, refer to [Section 19.1.1 – Completion Instructions for the UCF](#), [Section 19.2.1.1 – Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#) for non-compound claims, or [Section 19.2.2.1 – Completion Instructions for California Specific Compound Pharmacy Claim Form \(30-4\)](#) for compound claims. Providers mailing paper claim forms can view the mailing address in [Appendix B – Directory](#).

Six-Month Billing Limit

- Original (or initial) Medi-Cal Rx claims must be received by the Medi-Cal Rx vendor within six months following the month in which services were rendered. This requirement is referred to as the six-month billing limit.
 - **Example:** If services are provided on April 15, 2021, the claim must be received by the Medi-Cal Rx vendor prior to October 31, 2021, to avoid payment reduction or denial for late billing.

Billing Limit Exceptions

- Exceptions to the six-month billing limit can be made if the reason for the late billing is one of the billing limit exceptions allowed by regulations. Billing limit exceptions also have time limits. Refer to *Table 19.3.1-1* and *Table 19.3.1-2* below for a list of billing limit exception codes and required documentation.

Late Billing Instructions

Follow the steps below to bill a late claim that meets one of the approved exception reasons:

- Enter the appropriate billing limit exception reason code (1 through 8 or “A”) in the Delay Reason field (Field 46 (UCF)) or the Billing Limit Exception field (Box 75 (30-1), or Box 38 (30-4)) of the claim.
- Complete the Specific Details/Remarks (on the (30-1) or (30-4) form(s)) area with the information required for reason codes 1 (descriptions 1 and 2) and 3-5.
 - Providers submitting a UCF should enter the information required for reason code 1 (descriptions 1 and 2) and 3-5 in any available space on the form.
- Attach substantiating documentation to justify late submittal of the claim for reason codes 1 (description 2), 2, and 6-8. The Billing Limit Exceptions charts on the following pages describe the documentation required for each billing exception.
- Providers who do not meet any billing limit exception reasons when submitting claims during the seventh month (July) through the twelfth month (December) after the month of service should enter an “A” in the Delay Reason field (Field 46 (UCF), or Billing Limit Exception field (Box 75 (30-1) or Box 38 (30-4)) of the claim.

Claims Over One Year Old

- The Medi-Cal Rx vendor will review all original claims delayed over one year from the month of service due to court decisions, fair hearing decisions, county administrative errors in determining member eligibility, reversal of decisions on appealed PA requests, Medicare/OHC delays, or other circumstances beyond the provider's control. Claims submitted more than 12 months from the month of service must always use delay reason code "10" and must be billed hard copy with the appropriate attachments as listed in the table below.
 - Note:** Providers will receive a RA message indicating the status of their claim.
- Claims submitted to the Over-One-Year Claims Unit must include a copy of the member's proof of eligibility and one of the following documents with the late claim.

Refer to *Table 19.3.1-1* below for billing limit exceptions.

Billing Limit Exceptions		
Reason Code	Description	Documentation Needed
1	(1) Proof of eligibility unknown or unavailable; includes retroactive eligibility, or ID cards, if applicable.	In the <i>Specific Details/Remarks</i> area, enter month, day, and year when proof of eligibility was received. Example: Proof of eligibility received on March 15, 2006.
	(2) For SOC reimbursement processing.	Attach an SOC Medi-Cal Provider Letter (MC 1054) for SOC reimbursement processing.
2 *+	(1) OHC, including Medicare, Kaiser, CHAMPUS, and other health insurance.	With the Medi-Cal claim, submit a copy of the OHC Explanation of Benefits (EOB) or RA showing payment of denial.
	(2) Charpentier rebill claims. *	Submit a copy of the RA for the original crossover claim.
3 *	Authorization delays in PA approval.	In the <i>Specific Details/Remarks</i> area, enter only the approval date of the PA or CCS authorization
4 *	Delay by DHCS in certifying providers or by the Medi-Cal Rx vendor in supplying billing forms	In the <i>Specific Details/Remarks</i> area, enter a statement indicating the date of certification and/or the date billing forms were requested, and date received.

Billing Limit Exceptions		
Reason Code	Description	Documentation Needed
5 *	Delay in delivery of custom-made eye, prosthetic, or orthotic appliances.	In the <i>Specific Details/Remarks</i> area, enter a statement explaining why the appliance was not previously delivered to the member.
<p><u>Deadlines for Claim Receipt:</u></p> <p>† Claims related to these circumstances will be reimbursed at a reduced rate according to the date the claim was received by the Medi-Cal Rx vendor. Refer to Section 4.7.3 – Timely Filing Claim Cutback for information on reimbursement rate reduction.</p> <p>° Claims related to this circumstance must be received by the Medi-Cal Rx vendor no later than 60 days after the date indicated on the claim that proof of eligibility is received by the provider. Proof of eligibility must be obtained no later than one year after the month in which service was rendered.</p> <p>+ Claims related to these circumstances, together with the Medicare or OHC EOB/RA or denial letter, must be received by the OHC carrier no later than 12 months after the month of service and by the Medi-Cal Rx vendor within 60 days of the other health carrier's resolution (payment/denial).</p> <p>♣ Charpentier rebill claims must be received within 6 months of Medi-Cal Rx RA date for the original crossover claim.</p> <p>* Claims related to these circumstances must be <u>received</u> by the Medi-Cal Rx vendor no later than one year from the <u>month</u> of service.</p>		
6 *	Substantial damage by fire, flood, or disaster to provider records.	Attach a letter on provider letterhead describing the circumstances and date of occurrence. The letter must be signed by the provider or provider's designee.
7 **	Theft, sabotage, or other willful acts by an employee. Note: Negligence by an employee is <u>not</u> covered by this reason code.	Attach a letter on provider letterhead documenting the incident and the date the incident was reported to a law enforcement agency. The letter must be signed by the provider or provider's designee.

Billing Limit Exceptions		
Reason Code	Description	Documentation Needed
10 **	(1) Court order or State or administrative fair hearing decision.	Submit member proof of eligibility and the court order or fair hearing decision.
	(2) Delay or error in the certification or determination of Medi-Cal Rx eligibility.	Submit a copy of the original LOA form (MC-180) signed by an official of the county. In the <i>Specific Details/Remarks</i> area, indicate date received from the member.
	(3) Update of a PA beyond the 12-month limit.	Submit member proof of eligibility and copy of the updated PA
	(4) Circumstances beyond the provider's control as determined by DHCS.	Submit member proof of eligibility with either a copy of DHCS approval or a copy of the OHC (including Medicare) proof of payment or denial. Note: Claims submitted under this condition must have been billed to the OHC carrier within 12 months from the month of service
A +	Claims submitted after the 6-month billing limit and received by the Medi-Cal Rx during the 7th through 12th month after the month of service and none of the exceptions above apply.	None.
Deadlines for Claim Receipt: * Claims related to these circumstances must be <u>received</u> by Medi-Cal Rx no later than 1 year from the month of service. ** Claims related to these circumstances must be <u>received</u> by Medi-Cal Rx, no later than <u>one year</u> from the date of service. ** Claims related to these circumstances must be <u>received</u> by Medi-Cal Rx, no later than <u>60 days</u> after the date of resolution of the circumstance which caused the billing delay.		

Table 19.3.1-1: Billing Limit Exceptions

Note: Providers must bill Medicare or the OHC within one year of the month of service to meet Medi-Cal timeliness requirements.

The following guidelines in *Table 19.3.1-2* apply to over-one-year-old and original claims.

Over-One-Year Billing Exceptions		
Cause of Delay	Billing Limit Exception Code	Documentation Needed
Retroactive SSI/SSP	10	<ul style="list-style-type: none"> Copy of the original County Letter Authorization (LOA) form (MC-180) signed by an official of the county
Court Order	10	
State or Administrative Hearing	10	
County Error	10	
DHCS Approval	10	
Reversal of Decision on Appealed PA	10	<ul style="list-style-type: none"> Copy of the PA Copy of DHCS letter or court order reversing the PA denial Explanation of the circumstances in the <i>Specific Details/Remarks</i> area
Medicare/OHC	10	<ul style="list-style-type: none"> Copy of the OHC EOB Explanation of the circumstances in <i>Specific Details/Remarks</i> area

Table 19.3.1-2: Over-One-Year Billing Exceptions

19.3.2 Tips for Billing Crossover Claims

19.3.2.1 Billing Tips: Part B Services Billed to Part B Medicare Administrative Carriers

The following billing tips will help prevent rejections, delays, mispayments, and/or denials of crossover claims for Part B services billed to Part B Medicare Administrative Carriers (MACs):

- Submit non-automatic pharmacy crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the claim form) or the *California Specific Pharmacy Claim Form* (30-1).
- Submit non-automatic pharmacy compound crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the claim form) or the *California Specific Compound Pharmacy Claim Form* (30-4).
- If submitting a UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4), the background must be visible.
- A separate copy of the MRN must be submitted with each claim form.

- MRNs must be complete, legible, and unaltered. For example, make sure the date in the upper right-hand corner is legible.
- Crossover claims must not be combined. For example:
 - Multiple members on one UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4).
 - One MRN for multiple UCFs, *California Specific Pharmacy Claim Forms* (30-1), or *California Specific Compound Pharmacy Claim Forms* (30-4).
 - Multiple claims (on one or more MRNs) for the same member on one UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4).
 - Multiple claim lines from more than one MRN for the same member on one *California Specific Pharmacy Claim Form* (30-1) or *California Specific Compound Pharmacy Claim Form* (30-4).
- Only use NDC codes for specified Medicare-covered drugs.
- Use NDC codes when billing pharmacy crossovers on claim forms.
- All Medicare-allowed claim lines must be included on the crossover claim and must match each corresponding MRN provided by Medicare.
- Medicare-denied claim lines that appear on the same crossover claim MRN with Medicare-allowed claim lines cannot be paid with the crossover claim.
- If the member has OHC, submit a copy of the MRN or denial letter from the insurance carrier. Part B pharmacy crossovers billed using a UCF, *California Specific Pharmacy Claim Form* (30-1), and *California Specific Compound Pharmacy Claim Form* (30-4) do not require a copy of the MRN or denial letter from the other insurance carrier.

Submit Medicare adjustment crossovers on a CIF.

19.3.2.2 Billing Tips: Part B Services Billed to Part A Medicare Administrative Carriers

The following billing tips will help prevent rejections, delays, mispayments, and or denials of crossover claims for Part B services billed to Part A MACs:

- Submit non-automatic pharmacy crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the top of the claim form) or the *California Specific Pharmacy Claim Form* (30-1).
- Submit non-automatic pharmacy compound crossovers using NDCs on the UCF (providers must identify a Crossover claim on the UCF by notating CROSSOVER on the top of the claim form) or the *Compound Pharmacy Claim Form* (30-4).
- If submitting a UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4), the background must be visible.
- A separate copy of the MRN must be submitted with each claim form.
- MRNs must be complete, legible, and unaltered. For example, make sure the date in the upper right-hand corner is legible.

- Crossover claims must not be combined. For example:
 - Multiple members on one UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4).
 - One MRN for multiple UCFs, *California Specific Pharmacy Claim Forms* (30-1), or *California Specific Compound Pharmacy Claim Forms* (30-4).
 - Multiple claims (on one or more MRNs) for the same member on one UCF, *California Specific Pharmacy Claim Form* (30-1), or *California Specific Compound Pharmacy Claim Form* (30-4).
 - Multiple claim lines from more than one MRN for the same member on one *California Specific Pharmacy Claim Form* (30-1) or *California Specific Compound Pharmacy Claim Form* (30-4).
- Only use NDC codes for specified Medicare-covered drugs.
- Use NDC codes when billing pharmacy crossovers on claim forms.
- All Medicare-allowed claim lines must be included on the crossover claim and must match each corresponding MRN provided by Medicare.
- Medicare-denied claim lines that appear on the same crossover claim MRN with Medicare-allowed claim lines cannot be paid with the crossover claim.
- If the member has OHC, submit a copy of the MRN or denial letter from the insurance carrier. Part B pharmacy crossovers billed using a UCF, *California Specific Pharmacy Claim Form* (30-1), and *California Specific Compound Pharmacy Claim Form* (30-4) do not require a copy of the MRN or denial letter from the other insurance carrier.

Submit Medicare adjustment crossovers on a CIF.

19.3.3 Tips for Billing Charpentier Claims

19.3.3.1 Identifying a Charpentier Claim

After Medi-Cal Rx processes the crossover claim for Medicare-Covered drugs, and the above steps ([Section 19.2.1.1 - Completion Instructions for California Specific Pharmacy Claim Form \(30-1\)](#)) have been executed, complete the UCF, (30-1), and (30-4) fields in *Table 19.3.3.1-1* below for Charpentier rebills only:

Paper Claim Form Fields for Charpentier Rebills		
Field UCF (30-1) (30-4)	Description	Steps
Field 84/85 Box 26 Box 27	Other Payer Amount Paid #1/#2 Other Coverage Paid	Enter the sum of previous payments from Medicare, Medi-Cal Rx (crossover claim payment) and any OHC.
	<i>Specific Details/Remarks</i> area	Select one (1) of the following phrases, as previously defined in Section 10.4.2 – Charpentier Claims : <ul style="list-style-type: none"> • For <u>Rates</u>, enter the words “Medi/Medi Charpentier: Rates”

Paper Claim Form Fields for Charpentier Rebills		
Field UCF (30-1) (30-4)	Description	Steps
		<ul style="list-style-type: none"> For <u>Benefit Limitations</u>, enter the words "Medi/Medi Charpentier: Benefit Limitation" For <u>Both Rates and Benefit Limitations</u>, enter the words "Medi/Medi Charpentier: Both Rates and Benefit Limitation" Note: Providers submitting a UCF form should enter the information required for reason Code 1 (descriptions 1 and 2) and 3-5 in any available space on the form.
Box <u>10</u> Box <u>18</u>	Medicare Status	<p>Select one of the following letters that corresponds to the phrase entered in <i>Specific Details/Remarks</i> area:</p> <ul style="list-style-type: none"> For <u>Rates</u>, enter the letter "R" For <u>Benefit Limitation</u>, enter the letter "L" For Both Rates and Benefit Limitations, enter the letter "T" Note: Providers submitting a UCF form should enter the information that corresponds to the information entered regarding the information in the above box in any available space on the form.
Fields <u>37, 69</u> Boxes <u>21, 41, 62</u> Box <u>33</u>	Product ID	<p>If multiple claim lines were originally processed by Medicare and fewer claim lines are now being rebilled to Medi-Cal Rx, indicate with an asterisk (*) on the Medicare EOMB/MRN the items that are being rebilled to Medi-Cal for Charpentier processing. Also indicate the claim line number that corresponds to the asterisk(s).</p> <ul style="list-style-type: none"> When using an NDC, <u>indicate on the Medicare EOMB/MRN</u> (beside the line being rebilled) the Medi-Cal 30-1 claim line number that corresponds to the Medicare Product ID/item Note: Complete the claim using the NDC that most closely reflects the items/services provided and that most closely equates to the Medicare code originally billed to Medicare and to the code shown on the EOMB/MRN. The provider is certifying that the NDC on the claim best reflects the item or service <u>rendered</u> to the member.

Table 19.3.3.1-1: Paper Claim Form Fields for Charpentier Rebills

Additional billing tips for Charpentier claims to help in the prevention of rejections, delays, incorrect payments, and/or denials when rebilling Charpentier claims:

- A Charpentier rebill must not be combined with a crossover claim.
- Use of Charpentier indicators ("R," "L," or "T") on claims that are not Charpentier claims will result in processing delays.
- Failure to place a Charpentier indicator ("R," "L," or "T") on a legitimate Charpentier claim prevents the system from recognizing the claim as a Charpentier rebill which may result in processing delays or denial of the claim.
- Claims with incorrectly marked MRNs will be denied.
- Providers must obtain an approved PA if a PA would be required when billed as a Medi-Cal Rx only claim.
- Providers are not required to submit a copy of the Medicare Appeal and Decision form when billing Medi-Cal Rx for the difference between Medicare and Medi-Cal Rx's allowed amount.
- **Note:** If required information is missing either from the claim form or the attachments provided, Medi-Cal Rx will attempt to contact the provider to obtain and document the missing information. If Medi-Cal Rx is unable to reach the provider, the claim will be returned to with a letter requesting the missing information.

19.3.3.2 Charpentier Submission Requirements

All Charpentier rebilled claims **MUST** be processed first as a Part B Crossover Claim (refer to [Section 10.4.1 – Medicare Part B COB Claims](#)) and will ONLY be accepted via paper.

Note: A CIF should **NOT** be used to rebill a Charpentier claim.

Providers must use the following submission requirements to be considered for supplemental payment under the Charpentier injunction (refer to [Section 10.4.2 – Charpentier Claims](#)):

- Providers must first bill Medicare and OHC to which the member is entitled.
- The claim must then be billed as a crossover and approved by Medi-Cal Rx.
 - The claim may crossover automatically from the Part B carrier via electronic/POS submission OR the crossover claim may be billed via paper claim to Medi-Cal Rx by the provider.

Provider must obtain an approved PA if a PA would be required when billed as a Medi-Cal Rx claim only.

- Providers are NOT required to submit a copy of the Medicare Appeal and Decision form when billing Medi-Cal Rx for the difference between Medicare and Medi-Cal Rx.

All Charpentier claim rebills for pharmacy claims must be submitted via paper claim form and mailed to Medi-Cal Rx (refer to [Appendix B – Directory](#) for mailing address).

19.4 Medi-Cal Rx Provider Claim Inquiry Form (CIF) (DHCS 6570)

Providers should submit a CIF *after* submitting a claim to resolve claim payments or denials as identified on the RA. There are seven main reasons to submit a CIF:

- Reconsideration – A claim has been denied and a provider has information that would correct the reason for denial.
- Void – A request to repay monies on a previously paid claim.
- SOC – A claim has been paid at a different amount and a provider requests a reimbursement for SOC.
- Tracer – No record of payment of denial of a previously submitted claim exists on the RA and the provider wants to trace the status of a claim.
- Crossover – A request for reconsideration of a denied Crossover claim or an underpaid or overpaid Crossover claim.
- Underpayment – Adjustment for an underpaid claim.
- Overpayment – Adjustment for an overpaid claim.

Providers can access the CIF via the [Medi-Cal Rx Provider Portal](#) by selecting the [Forms & Information](#) link. The CIF also contains additional instructions on how to complete the required form fields. Refer to *Figure 19.4-1*.

Note: The Medi-Cal Rx Provider Claim Inquiry process is applicable to pharmacy FFS claims processed by Medi-Cal Rx or CA-MMIS.

CIFs can be mailed to the Medi-Cal Rx Claims Department (refer to [Appendix B – Directory](#) for the mailing address).

Refer to *Figure 19.4-1* for a sample of a completed CIF.

Provider Claim Inquiry Form (CIF)



Instructions: The Provider Claim Inquiry Form (CIF) is used to resolve claim payments or denials as identified on the Remittance Advice (RA). Please carefully read the enclosed instructions prior to completing and signing the CIF. All required fields must be completed to process the Provider Claim Inquiry.

Providers must print, sign, date, and mail the form as per the instructions in the *Form Submission* section. Explanations regarding form fields are located below the form in the *Explanation of Provider Claim Inquiry Form* section. Incomplete forms will not be processed and will be returned to the provider.

* Indicates Required Field

PART 1 – Provider Information	
*Provider Name: ABC Provider	
*Service Address: 123 Any Street	
*City: Anytown	
*State: CA	*ZIP Code: 99999-5555
*National Provider Identifier (NPI) Number: 123456789	
PART 2 – Claim Information	
*Claim Type: <input checked="" type="checkbox"/> 01 – Pharmacy	
*Beneficiary Name: Jane Smith	
*Beneficiary Medi-Cal ID Number: 98745632A	
*For each claim line (up to five claims per form) complete all applicable fields.	
01	Prescription Number: 5648210 Date of Service: 12/21/2021
	NDC or Medical Supply Billing Code: 09874563210 Amount Billed: \$250.00
	<input checked="" type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover
	<input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input checked="" type="checkbox"/> Attachments (Number of Attachments: 3)

02	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
03	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
04	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
05	Prescription Number: _____ Date of Service: _____ NDC or Medical Supply Billing Code: _____ Amount Billed: \$ _____ <input type="checkbox"/> Reconsideration <input type="checkbox"/> Void <input type="checkbox"/> Share of Cost (SOC) <input type="checkbox"/> Tracer <input type="checkbox"/> Crossover <input type="checkbox"/> Underpayment <input type="checkbox"/> Overpayment <input type="checkbox"/> Attachments (Number of Attachments: _____)
*Total Attachments (Required when attachments are included): 3	
*Remarks: (Such as: Corrections or additional information necessary to resubmit a denied claim or request an adjustment for an underpayment or overpayment. What went wrong with the claim? What has the biller/provider done to correct the claim? What do you want Medi-Cal Rx to do with the claim? If listing multiple claims on the CIF, specify to which claim each remark applies.) Please reconsider processing the above claim. It was denied for eligibility when patient was eligible at time of service (please see attached eligibility verification).	

PART 3 – Provider Certification

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on this form. The signature of the provider or the Authorized Representative binds the provider to statements and conditions contained in this form.

***Signature of Provider or Authorized Representative (Original Signature Required; Use Blue Ink):**

John Doe

***Print Name:**

John Doe

***Date:**

12/31/2021

Form Submission

Print, sign, date, and mail this completed form to the address below. If you have questions about completing this form, please call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

Medi-Cal Rx Customer Service Center
ATTN: Provider Claim Inquiries
P.O. Box 610
Rancho Cordova, CA 95741-0610

▲ Explanation of Provider Claim Inquiry Form

The CIF is used to resolve claim payments or denials as identified on the Remittance Advice (RA). There are seven main reasons to submit a CIF:

- **Reconsideration** – A claim has been denied and a provider has information that would correct the reason for denial.
- **Void** – Reverse payment on a claim.
- **Share of Cost (SOC)** – A claim has been paid at a different amount and a provider requests a reimbursement for Share of Cost (SOC).
- **Tracer** – No record of payment or denial of a previously submitted claim exists on the RA and a provider wants to trace the status of a claim.
- **Crossover** – Refer to the *Medicare Part B Crossover Claims* section of the *Medi-Cal Rx Provider Manual* for more information.
- **Underpayment** – A claim has been underpaid and a provider requests an adjustment.
- **Overpayment** – A claim has been overpaid and a provider requests an adjustment.

Refer to the *Claim Inquiry Form* section of the *Medi-Cal Rx Provider Manual* at <https://medi-calrx.dhcs.ca.gov/provider/forms> for additional information regarding types of inquiries, timeliness of submission, special billing instructions, exceptions to using a CIF, acceptable attachments, completion reminders, response to CIF and completion tips.

Explanation of Form Fields

Provider Information

Provider Name: Enter the provider name.

Service Address, City, State, ZIP Code: Enter the service address for the provider.

National Provider Identifier (NPI) Number: Enter the provider's NPI number.

Claim Information

Claim Type: Defaulted to Pharmacy. For claim inquiry information for other claim types (e.g., Long Term Care, Inpatient, Outpatient, Medical), visit <https://www.medi-cal.ca.gov/>.

Beneficiary Name: Enter the beneficiary's first and last name.

Beneficiary Medi-Cal ID Number: Enter the beneficiary ID number that appears on the RA showing adjudication of that claim.

Prescription Number: Enter the prescription number.

Date of Service: Enter dates in a MM/DD/YYYY format.

NDC or Medical Supply Billing Code: Enter the National Drug Code (NDC) or 11-digit NDC-like medical supply billing code. When submitting an inquiry for a compound drug claim, enter zero ("0") in place of listing the NDCs, and include each ingredient NDC with the attachment(s).

Amount Billed: Enter the dollar amount originally billed.

Reconsideration: Select this box for a denied claim reconsideration request.

Void: Select this box for a void request.

Share of Cost (SOC) Reimbursement: Select this box for a Share of Cost Reimbursement request.

Tracer: Select this box for a tracer request.

Crossover: Select this box for a Medicare Part B Crossover adjustment request.

Underpayment: Select this box for an underpayment adjustment request.

Overpayment: Select this box for an overpayment adjustment request.

Attachments: Select this box if including attachments related to the request. Note that all claim inquiries should have attachments except when requesting a tracer.

Number of Attachments: Enter the number of attachments submitted for each request.

Total Attachments: Enter the total number of attachments for all requests included on the form.

Remarks: Enter comments specific to each claim on the CIF. If listing multiple claims on the CIF, please specify to which claim each remark applies using the line numbers from the previous section.

Provider Certification

Signature of Provider or Authorized Representative: The signature of the provider or the provider's authorized representative. An original signature is required; use blue ink.

Print Name: Print the name of the person signing the form.

Date: The date on which the form is signed.

Figure 19.4-1: Medi-Cal Rx Provider Claim Inquiry Form (DHCS 6570)

19.4.1 Types of CIF Inquiries and Timelines

Refer to *Table 19.4.1-1* below for descriptions and timelines of various inquiry types.

Type	Description	Timelines and Additional Notes
Reconsideration	This inquiry type is for a claim that has been denied, and a provider has information that would correct the reason for denial.	<p>Within Six-Month Billing Limit: If a claim is denied and the DOS is within the six-month billing limit or the billing limit exceptions time frame, a corrected claim may be submitted (via POS, WCS, or paper claim) instead of completing a CIF.</p> <ul style="list-style-type: none"> • Note: Submitting a new claim within the original six-month billing limit may be a faster process. <p>Beyond Six-Month Billing Limit: To request a reconsideration of a denied claim after the six-month billing limit, providers must complete all applicable and required fields of the CIF and attach a legible copy of the corrected original claim form, a copy of the RA dated within six months of the denial date, and all other pertinent information. (Refer to Section 4.7.2 – Six-Month Billing Limit and Section 19.3.1 – Submission and Timeliness Instructions for additional information regarding timeliness and timeliness exceptions.)</p> <ul style="list-style-type: none"> • Note: CIFs received after six months are subject to automatic denial.
Void (Reversals)	This inquiry type is used to request a void. A void can be requested to fully repay monies previously paid by Medi-Cal Rx.	<p>Void Requests may be submitted <i>any time</i>.</p> <ul style="list-style-type: none"> • Note: Voids can be done via the Medi-Cal Rx POS or WCS if the claim has a DOS on/after 10/01/2019. <p>Refer to Section 19.4.2.3 – Voids and Resubmissions for additional information regarding CIF Voids.</p>

Type	Description	Timelines and Additional Notes
SOC	This inquiry type is used to request SOC reimbursement. An SOC reimbursement can be requested to fully recover or recoup monies paid toward a member's SOC.	SOC adjustments must be made within six months following the date of payment on an RA. Refer to Section 19.4.2.2 – CIFs for SOC Reimbursement Claims for additional information regarding SOC Reimbursement.
Tracer	CIF Tracers are submitted by providers who have no record of a payment or denial of a previously submitted claim on an RA, and the provider wants to trace the status of a claim. When a CIF is designated as a tracer, the Medi-Cal Rx Claims Department will search the payment records and will send a letter to the listed provider advising whether a record exists for the claim specified. If a record is found, the letter will specify the action taken on the claim (date of payment, date of denial).	Tracers may be submitted at any time. However, if a tracer is being used to prove timely submission of a claim, the CIF must be received within the same six-month billing limit for claims. If there is no record of receipt of the claim, a Provider Claim Appeal with copies of supporting documentation may be submitted (refer to Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and corresponding subsections for additional information). Providers should not send any additional documents with a tracer.
Crossover	This inquiry type is used to request reconsideration of a denied Medicare Crossover claim, an adjustment of an underpaid or overpaid Medicare Crossover claim, or an adjustment related to a Medicare adjustment.	Crossover Underpayment Requests must be made within six months following the date of payment on an RA. CIFs received after six months from the date of the RA on which the underpayment was indicated are subject to automatic denial. <ul style="list-style-type: none"> • Note: Charpentier claims must not be submitted on a CIF. Refer to Section 10.4.2 – Charpentier Claims for additional information. Refer to Section 19.4.2.5 – Medicare/ Medi-Cal Rx Crossover Claims for additional instructions on how to complete a CIF for Medicare/ Medi-Cal Rx Crossover claims.

Type	Description	Timelines and Additional Notes
Underpayment	This inquiry type is used when a claim has been paid at a different amount from the expected maximum allowable and a provider requests an adjustment for underpayment.	<p>Underpayment Requests must be made within six months following the date of payment on an RA. CIFs received after six months from the date of the RA on which the underpayment was indicated are subject to automatic denial.</p> <ul style="list-style-type: none"> • Note: Claims submitted after the six-month billing limit and received without a delay reason will be reimbursed at a reduced rate according to the date which the claim was received. <p>Refer to Section 4.7.2 – Six-Month Billing Limit and Section 19.3.1 – Submission and Timeliness Instructions for additional information regarding timeliness and timeliness exceptions.</p>
Overpayment	This inquiry type is used when a claim has been paid at a different amount from the expected maximum allowable and a provider requests an adjustment for overpayment.	Overpayment Requests may be submitted at any time.
Additional/ Subsequent Inquiries	If further action is desired after a claim inquiry appears on the RA as paid or denied, providers may submit another CIF or a Provider Claim Appeal.	All subsequent CIFs must be submitted within six months from the date of the RA. A Provider Claim Appeal (refer to Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571) for additional information) must be submitted within 90 days.

Type	Description	Timelines and Additional Notes
		Include copies of all previous and pertinent documentation with any CIFs or appeals submitted to substantiate timely follow-up (such as <i>Medi-Cal Rx Claim Inquiry Acknowledgement Letter, RA, or Medi-Cal Rx Claim Inquiry Response Letter</i>).

Table 19.4.1-1: CIF Inquiry Types and Timelines

19.4.2 CIF Completion Instructions

Providers should utilize the CIF and the following subsections for details and information on how to complete the CIF.

19.4.2.1 Tips for CIF Completion

The following information can be used for completing a CIF.

- Providers must fill out each applicable line completely.
- Do not use ditto marks (""") nor draw an arrow to indicate repetitive information on the CIF.
- Do not use staples on your paper claims. Staples may delay processing time. Providers may use paper clips.
- All information must be exactly the same as that on the RA (including the Beneficiary Medi-Cal ID Number, Prescription/Rx number, DOS, etc.).
 - For example, an incorrect ID number on the RA should be copied exactly the same on the CIF.
- CIFs may contain up to five claim lines per form, but all lines must be for the same member.
- CIFs must contain the applicable DOS of the claim(s) in the completed claim lines.
- All supporting documentation must be clear, concise, and complete.
- Failure to check the Attachment box may cause the claim to be denied (refer to [Section 19.4.4 – CIF Attachments](#) for additional information).
- Providers submitting a CIF for Underpayment or Overpayment must check the appropriate box on the applicable claim line. Failure to check the Underpayment or Overpayment box, when applicable, may cause a delay in claim processing.
- Providers submitting a CIF for Reconsideration of a denied claim must check the appropriate box on the applicable claim line. Do not check the Underpayment or Overpayment box if submitting a CIF for Reconsideration of a denial. Failure to check the Reconsideration box, when applicable, may cause a delay in claim processing.
- Providers submitting a CIF for Crossover must check the Crossover box and check the appropriate boxes for action to be taken (such as, Reconsideration, Void, Underpayment, or Overpayment) on the applicable claim line.

- Failure to complete the Remarks section of the CIF may cause claim denial or delayed processing.
- Do not use the Remarks section for additional inquiries.
- State clearly and precisely what is being requested in the Remarks section.
- For Underpayment or Reconsideration CIFs, always indicate the denial reason code from the RA in the Remarks section.
- An RA is not required for SOC or Tracer CIFs.
- Do not attach any documentation for Tracer CIFs.
- Only original CIFs are accepted. Photocopied CIFs will be returned.
- Validate that timeliness requirements are met; refer to [Section 19.4.1 – Types of CIF Inquiries and Timelines](#) for additional information.
 - **Note:** Providers submitting improperly completed CIFs will receive a Medi-Cal Rx Claim Inquiry Acknowledgement Letter. The Acknowledgement will advise the provider that the CIF is rejected, what information is missing, and to resubmit a corrected CIF. Providers should include the Medi-Cal Rx Claim Inquiry Acknowledgement Letter and all other pertinent documentation with the resubmitted CIF. Refer to [Section 19.4.5.1 – Acknowledgement and CIF Processing](#) for additional information on Medi-Cal Rx Claim Inquiry Acknowledgments.

19.4.2.2 CIFs for SOC Reimbursement Claims

In addition to the submission requirements outlined on the CIF and in [Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form \(CIF\) \(DHCS 6570\)](#) and the associated subsections, use the following instructions to request SOC reimbursement for previously paid claims:

- For SOC CIFs, enter the member's original ID (the number issued prior to being enrolled in a no-SOC program).
- In the Remarks section of the CIF, state "SOC reimbursement; MC 1054 attached."
- An RA is not required for SOC CIFs.
- Attach a Share-of-Cost Medi-Cal Provider Letter (MC 1054).
 - **Note:** If requesting SOC reimbursement for denied claims or claims not previously submitted, submit the MC 1054 with the new claim attached to the CIF.
- If SOC is reduced to an amount other than zero, wait a minimum of 30 days before submitting a CIF.

19.4.2.3 Voids and Resubmissions

A CIF Void can be requested to fully repay monies paid by Medi-Cal Rx. In many instances, the provider's goal is to return funds. Void requests may be submitted at any time. Voids can be done via the Medi-Cal Rx POS or WCS if the claim has a DOS *on or after* 10/01/2019.

Providers requiring a void and subsequent resubmission of a corrected claim must use a two-step process. The CIF void must first be submitted to recoup the full payment. Once the void appears on a future RA, the provider completes the second step by submitting a corrected claim for processing.

Note: If a provider submits a corrected claim before the void has been processed, the claim may deny as a duplicate since the original claim has not yet completed the void process.

19.4.2.4 CIFs for Compound Claims

A pharmacy compound claim with numerous ingredients is processed as one line. An inquiry may not be made for individual ingredients on a compound claim. Therefore, only one claim line should be completed per compound claim on a CIF.

When submitting a CIF for a compound drug claim, enter '0' in the NDC field of the applicable claim line, in place of listing each NDC. Include each ingredient NDC with the supporting attachments (refer to [Section 19.4.4 – CIF Attachments](#) for information on acceptable documentation).

19.4.2.5 Medicare/Medi-Cal Rx Crossover Claims

19.4.2.5.1 Submitting Crossover CIFs

In addition to the submission requirements outlined in [Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form \(CIF\) \(DHCS 6570\)](#) and the associated subsections, use the following instructions to complete a CIF for Medicare/Medi-Cal Rx Crossover claims. A CIF may be used to request reconsideration of a denied Crossover claim, an adjustment of an underpaid or overpaid Medicare Crossover claim, or an adjustment related to a Medicare adjustment.

Note: Charpentier claims must **not** be submitted on a CIF. Refer to [Section 10.4.2 – Charpentier Claims](#) for additional information.

Always include supporting documentation with a Crossover CIF, or the claim will be denied.

19.4.2.5.2 Reconsideration of Denied Crossover Claims

Follow the instructions below to complete a CIF for reconsideration of a denied Crossover claim:

- Check the Attachment box in the corresponding claim line on the CIF.
- Attach the following documentation:
 - If Part B services are billed to a Part A intermediary, submit a clear copy of the original Crossover claim form billed to Medi-Cal Rx.
 - If Part B services are billed to a Part B carrier, submit a clear copy of one of the following:
 - Original Crossover claim form billed to Medi-Cal Rx
 - Claim form billed to Medicare
 - Copy of the claim form submitted to Medicare
 - **Note:** All claims for Part B services must include a clear copy of both of the following:
 - MRN/Medicare National Standard Intermediary RA
 - Medi-Cal Rx RA showing the Medi-Cal Rx Crossover denial

- In the Remarks section, indicate the denial code and include any additional information needed to correct the claim.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the **Remarks** section is completed and specifically identifies what corrections are being made.

19.4.2.5.3 Adjustments to Medi-Cal Rx Crossover Payments

Follow the instructions below to complete a CIF for an adjustment to a Medi-Cal Rx Crossover payment:

- Check the Attachment box in the corresponding claim line on the CIF.
 - **Note:** All claims for Part B services must include a clear copy of both of the following:
 - MRN/Medicare National Standard Intermediary RA
 - Medi-Cal Rx RA showing the Medi-Cal Rx Crossover denial
- In the Remarks section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the **Remarks** section is complete and specifically identifies what corrections are being made.

19.4.2.5.4 Adjustments Related to Medicare Adjustments

When Medicare automatically crosses over a Medicare adjustment, it is not processed by Medi-Cal Rx because Medi-Cal Rx does **not** process Medicare adjustments. As a result, the Medicare adjustment claim **must** be submitted in hard-copy form.

Providers need to properly adjust the original claim submitted to Medicare and resubmit the adjusted claim to Medi-Cal Rx. Providers must also *void* (reverse) the original Medicare payment, or the adjusted claim will be denied due to a duplicate of a previously paid claim.

To receive the correct reimbursement from Medi-Cal Rx for a previously reimbursed Medicare Crossover claim, providers may either submit a CIF or file a Provider Claim Appeal (refer to [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes](#) and corresponding subsections and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information).

When completing a CIF due to a Medicare adjustment, follow these additional instructions:

- Check the Attachment box in the corresponding claim line on the CIF.
- Attach the following documentation for an adjustment related to a Medicare adjustment:
 - If Part B services are billed to a Part B carrier, submit a clear copy of the adjusted Medicare claim form and one of the following:
 - Original Crossover claim form billed to Medi-Cal Rx
 - Original claim form billed to Medicare
 - Copy of the original claim form submitted to Medicare

- **Note:** All claims for Part B services must include a clear copy of both of the following:
 - Original and adjusted MRN/Medicare National Standard Intermediary RA
 - Medi-Cal Rx RA showing the Medi-Cal Rx Crossover payment or denial
- In the Remarks section, indicate the specific reason for the adjustment and the type of action desired.

Note: It is acceptable to make corrections on the claim copy being submitted with the CIF if the **Remarks** section is complete and specifically identifies what corrections are being made.

19.4.2.5.5 Tracing Crossover Claims

A CIF must be submitted to trace a Crossover claim. Providers submitting a CIF to trace a Crossover claim must check the **Tracer** and **Crossover** boxes on the applicable claim line.

Note: Do **not** submit a Crossover claim to trace a Crossover claim.

19.4.3 Exceptions to Using CIFs

Refer to *Table 19.4.3-1* below for information regarding when CIFs **may** not be used.

Type	Description
Pharmacy Claims: POS Network	<p>Do not submit a hard-copy CIF to void (reverse) a pharmacy claim originally submitted over the POS network <i>unless</i> an overpayment is being returned. Instead, reverse the claim over the POS network and then resubmit a corrected claim if necessary. For assistance in reversing a claim via the POS network, contact the CSC at 1-800-977-2273.</p> <p>Note: A reversal via POS Network can be done for FFS claims with a DOS on/after 10/01/2019.</p>
Pharmacy Claims: WCS	<p>Pharmacy providers should not submit a hard-copy CIF to void (reverse) a claim originally submitted via WCS <i>unless</i> an overpayment is being returned. Instead, reverse the claim through the WCS system and then resubmit a corrected claim if necessary. For assistance in reversing a claim via WCS, contact CSC at 1-800-977-2273.</p> <p>Note: A reversal via POS Network can be done for FFS claims with a DOS on/after 10/01/2019.</p>
Compound Claims	<p>Do not submit a CIF to request reconsideration of a denied <i>pharmacy compound</i> claim if ingredients must be added or deleted. Instead, submit a new original claim within the six-month billing limit or billing limit exceptions time frame. If this period has expired, submit a Provider Claim Appeal (refer to Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571) for additional information).</p> <p>A pharmacy compound claim with numerous ingredients is processed as one line. A CIF may not be made for individual ingredients on a compound claim. Therefore, only one claim line should be completed per compound claim on a CIF.</p>

Type	Description	
Certain RA Codes	Do not submit a CIF for the following RA codes. Providers should submit a <i>Provider Claim Appeal Form</i> instead. If the claim has a unique circumstance requiring human intervention, a review by a person in the appeals unit is commonly used to resolve the specific denials listed below. Additional information is available in Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes and Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571) and corresponding subsections.	
	RA/NCPDP Code	Code Description
	65	Patient is not covered
	83	Duplicate Paid/Captured Claim
	67	Filled Before Coverage Effective
	68	Filled After Coverage Expired
	69	Filled After Coverage Terminated
	77	Discontinued Product/Service ID Number

Table 19.4.3-1: Exceptions to Using CIFs

19.4.4 CIF Attachments

All claim inquiries should have attachments *except* when submitting a tracer. Acceptable CIF attachments are as follows:

- Original Claim
- PA Request
- EOMB/MRN/Medicare RA
- EOB from OHC
- List of compound drug ingredients
- Copy of POS printout or internet eligibility response attached to the claim
- MC 1054 (SOC reimbursement) form
- Corrected claim noting remarks area, stating the reason and the amount of overpayment return

Note: All supporting documentation must be legible.

19.4.5 Acknowledgement, Response, Review, and Status of a Claim Inquiry

19.4.5.1 Acknowledgement and CIF Processing

Within **7 days** of receipt, the Medi-Cal Rx Claims Department will acknowledge all requests with a *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*. If Medi-Cal Rx makes any adjustment to the claim, it will appear on a future RA. The RA will reflect a negative and positive payment. The Medi-Cal Rx Claims Department will send a *Medi-Cal Rx Claim Inquiry Response Letter* 30 days after the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*.

- If a Medi-Cal Rx Claim Inquiry Acknowledgement Letter is not received or the claim submitted does not appear on an RA, a Provider Claim Appeal (refer to [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes](#) and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information) may be filed.

Status Numbers and Messages

Only **one** *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* is sent to providers for each CIF submitted. *Table 19.4.5.1-1* lists the status numbers and messages used in the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*.

Status Numbers and Messages	
Status	Message
00	Rejected. Freeform message displays detailed description of rejection.
01	Complete for resubmission of denied claim or underpayment/overpayment.
02	Complete. <i>Medi-Cal Rx Tracer Status Letter</i> will be generated.
03	Rejected. The Member Medi-Cal ID Number field is blank on form.
04	Complete for submission of void.
05	Rejected. The date of service is blank on form.
06	Rejected. The Rx number is blank on form.
07	Rejected. No MC 1054 form submitted with form.
08	Rejected. No EOMB, RA, or claim submitted with form.
09	Rejected. Original signature is not present on form.

Table 19.4.5.1-1: Status Numbers and Messages

19.4.5.2 Review of CIF

19.4.5.2.1 Underpayment/Overpayment/Reconsideration/Crossover CIF Review Process

For underpayment, overpayment, and reconsideration, the Medi-Cal Rx Claims Department takes the information found in the inquiry and reviews all information presented, both in the computer inquiry and in the attachments submitted with the CIF, and then processes the new claim according to Medi-Cal Rx policy.

It is important that the information entered on the CIF exactly matches what is displayed on the RA, even if the information is wrong. This assists in finding the claim in history files if available.

Note: If any information is missing or incomplete, the Medi-Cal Rx Claims Department will return the inquiry to the provider along with a Medi-Cal Rx Claim Inquiry Acknowledgement Letter identifying what information is missing and will also request CIF resubmission once corrected.

19.4.5.2.2 Tracer CIF Review Process

A tracer request is submitted when no record of payment or denial of a previously submitted claim exists on the RA. The Medi-Cal Rx Claims Department searches claim payment history based on the information submitted by the provider.

If the claim is not found, the *Medi-Cal Rx Tracer No Hit Letter* is mailed to the provider. When a claim is not found in history, providers should compare the data shown on the claim to the Tracer submitted. If the information differs, submit a corrected Tracer. If the claim you are tracing is still within the six-month billing limitation, you may resubmit an original claim. If the information is correct and more than 60 days have elapsed since the submission of the original claim, file an appeal.

If the claim is found, the *Medi-Cal Rx Tracer Hit Letter* is created and mailed to the provider detailing the findings of the inquiry.

Note: It is important that the information entered on the CIF exactly matches what was submitted on the claim, even if the information is wrong.

19.4.5.2.3 Void CIF Review Process

A CIF Void can be requested to fully repay monies paid by Medi-Cal Rx. In many instances, the provider's goal is to return funds. The Medi-Cal Rx Claims Department searches claim payment history based on the information submitted by the provider CIF. A "void" adjustment appears on the RA as a single line with a negative (-) amount.

Providers requiring a void and subsequent resubmission of a corrected claim must use a two-step process. The CIF void must first be submitted to recoup the full payment. Once the void appears on a future RA, the provider completes the second step by submitting a corrected claim for processing. If a provider submits a corrected claim before the void has been processed, the claim may deny as a duplicate since the original claim has not yet completed the void process.

19.4.5.3 Claim Inquiry Response Letter

- A Medi-Cal Rx Claim Inquiry Response Letter indicating the status of the claim is sent to providers when the CIF is completed. The Medi-Cal Rx Claim Inquiry Response Letter includes the date that the CIF was received and is used to verify that the CIF was submitted within the six-month billing limit.
- If the Medi-Cal Rx Claim Inquiry Response Letter states that the claim cannot be located, resubmit the claim as a Provider Claim Appeal (refer to [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Process](#) and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information). Enclose any necessary attachments, including a copy of the Medi-Cal Rx Claim Inquiry Response Letter.
- Providers may receive a Medi-Cal Rx Claim Inquiry Response Letter requesting additional information. To submit a new CIF, follow the instructions in the Medi-Cal Rx Claim Inquiry Response Letter.

19.4.5.4 Status Inquiries

Providers may inquire about the status of a CIF by calling the CSC at 1-800-977-2273 and referencing the claim prescription number and the member's Medi-Cal ID number. If a status request is submitted and received by mail, any written correspondence regarding claim lines referenced on a CIF acknowledgement should include copies of the *Medi-Cal Rx Claim Inquiry Acknowledgement Letter*, CIF, and all other pertinent documents.

19.4.5.5 Filing a Provider Claim Appeal

Providers who want to pursue further action may file a Provider Claim Appeal (refer to [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Process](#) and [Section 19.5 – Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for additional information).

19.5 Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)

19.5.1 Completion Instructions for the Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)

Refer to *Figure 19.5.1-1* for an example of a blank *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

Information regarding provider claim appeal processes can be found in [Section 5.0 – Medi-Cal Rx Provider Claim Appeal Processes](#).

The *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

The Medi-Cal Rx Claim Appeal Team reviews each claim individually using the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) and any acceptable attachments provided to render a fair decision.

Complete the fields on the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) according to the type of appeal as described in the following paragraphs. Resubmission, underpayment, and overpayment requests for the same member may be combined on one *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571). However, each appeal should include only one member.

Required Fields

Complete any fields that are required (required fields are identified by a red asterisk [*] on the form). If any required fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) and all supporting documentation and proof of timely follow-up and submission.

Notes:

- The **correct** Member Medi-Cal ID number must be entered in *Part 2 – Claim Information* of the form, even if the RA reflects an incorrect Member Medi-Cal ID number.
- If a provider is submitting a claim appeal for any reason other than those listed as checkboxes in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571), the reason must be explained in the provided lines of this part of the form.

Appeal a Claim Denial

If appealing a claim denial, enter the denial code from the RA in the applicable claim line under **EOB/RA Code** in *Part 2 – Claim Information* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

Underpayment and Overpayment Adjustments

If requesting reconsideration of an underpayment or overpayment, enter the payment code from the RA in the applicable claim line under **EOB/RA Code** in *Part 2 – Claim Information* and check the appropriate box in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571).

Note: The above also applies to crossover claim adjustment appeals.

If requesting an underpayment or overpayment *adjustment*, attach a legible copy of the original claim form, corrected if necessary, and a copy of the corresponding paid RA.

If requesting an *overpayment* adjustment because the member named is not a provider's patient, attach only a copy of the paid RA.

Correcting NDCs/Medical Supply Billing Codes

To correct the NDC and/or 11-digit NDC-like medical supply billing code information previously submitted on a claim form, complete the required fields identified above. Enter the **correct** NDC/11-digit NDC-like medical supply billing information (Product ID Qualifier, Product ID, Unit of Measure Qualifier, or NDC/11-digit NDC-like medical supply billing code) in *Part 3 – Appeal Reason* of the form.

Compound Claim Appeals

When submitting an appeal for a compound drug claim, enter zero ("0") in place of listing the NDCs and include each ingredient NDC with the attachment(s).

Tracer CIF Appeals

If a provider submits a *Tracer* CIF and the result is that there has been no record of receipt of the claim, a claim appeal may be submitted. Providers **must** include the details of the reason in *Part 3 – Appeal Reason* of the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) along with copies of any supporting documentation. Refer to [Section 19.4 – Medi-Cal Rx Provider Claim Inquiry Form \(CIF\) \(DHCS 6570\)](#) and corresponding subsections for additional information on CIFs.

Note: If a provider files a claim appeal following the submission, acknowledgement, and response of a CIF, the appeal **must** be submitted within 90 days from the date of the *Medi-Cal Rx Claim Inquiry Response Letter* and must include any previous and pertinent documentation (such as *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* or *Medi-Cal Rx Claim Inquiry Response Letter*, RA, etc.).

Provider Claim Appeal Form



Instructions: The Provider Claim Appeal Form may be submitted for unsatisfactory responses to the processing, payment, and resubmission of a claim or a claim inquiry. Medi-Cal Rx Claim Appeal Team reviews each claim individually using the documents presented by the provider to render a fair decision. Please carefully read the enclosed instructions prior to completing and signing the Provider Claim Appeal Form. All required fields must be completed to process the Provider Claim Appeal.

Providers must print, sign, date, and mail the form as per the instructions in the *Form Submission* section. Explanations regarding form fields are located below the form in the *Explanation of Provider Claim Appeal Form* section. Incomplete forms will not be processed and will be returned to the provider.

* Indicates Required Field

PART 1 – Provider Information

*Provider Name: ABC Provider

*Service Address: 123 Any Street

*City: Anytown

*State: CA

*ZIP Code: 99999-5555

*National Provider Identifier (NPI) Number: 123456789

PART 2 – Claim Information

*Claim Type: ☒ Pharmacy

As provided by the *California Administrative Code, Title 22, Section 51015 (b-d)*, I am submitting an appeal of my claim as defined below. Enclosed are all pertinent documents corresponding to the appeal, including copies of the claim, Explanation of Benefits (EOB), Remittance Advice (RA), Claim Inquiry Form (CIF), Medicare Explanation of Medicare Benefits (EOMB)/Medicare Remittance Notice (MRN), and previous correspondence with Medi-Cal Rx.

*Beneficiary Name: Jane Smith

*Beneficiary Medi-Cal ID Number: 98745632A

*For each claim (up to eight claims per form) fill in all claim line information in the associated row below.

	Rx Number	Date of Service (MM/DD/YYYY)	NDC or Medical Supply Billing Code	EOB/RA Code	Number of Attachments
1	8512346	12/21/2021	09876543210	001	3
2					
3					
4					
5					
6					
7					
8					
Total Attachments:					3

PART 3 – Appeal Reason

*Describe the **Appeal Reason** below and enclose all supporting documents, including a copy of the claim. Check all that apply. Refer to the *Claim Appeal Processes* section of the *Medi-Cal Rx Provider Manual* for additional information and guidelines regarding the appropriate items to be submitted with an appeal. If listing multiple claims on the Provider Claim Appeal Form, specify to which claim each reason applies.

☒ Eligibility (Proof of Eligibility attached)

☐ Crossover (EOMB attached)

☐ Adjustment Request (Refer to the *Supporting Documentation for Appeals* section of the *Medi-Cal Rx Provider Manual* for required supporting documentation)

☐ Other Reason (please describe below):

Please reconsider processing the above claim. It was denied for eligibility when patient was eligible at time of service. See attached Eligibility Verification, RAD, and the original claim.

PART 4 – Provider Certification

Privacy Statement (Civil Code Section 1798 et seq.): The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not processed.

This is to certify that the information contained above is true, accurate, and complete and that the provider has read, understands, and agrees to be bound by and comply with the statements and conditions contained on this form. The signature of the provider or the authorized representative binds the provider to statements and conditions contained in this form.

***Signature of Provider or Authorized Representative (Original Signature Required; Use Blue Ink):**

John Doe

***Print Name:**

John Doe

***Date:**

12/31/2021

Form Submission

Print, sign, date, and mail this completed form to the address below. For assistance in completing this form, please call the Medi-Cal Rx Customer Service Center at 1-800-977-2273.

Medi-Cal Rx Customer Service Center
ATTN: Provider Claim Appeals
P.O. Box 610
Rancho Cordova, CA 95741-0610

Explanation of Provider Claim Appeal Form

A claim appeal is the final step in the administrative process and a method for Medi-Cal Rx providers with a dispute to resolve problems related to their claims. Resubmission, underpayment, and overpayment requests for the same beneficiary may be combined on one form. However, each claim appeal should include only one beneficiary.

Refer to the *Claim Appeal Processes* and *Provider Claim Appeal Form* sections in the *Medi-Cal Rx Provider Manual* at <https://medi-calrx.dhcs.ca.gov/provider/forms> for claim appeal submission requirements.

Explanation of Form Fields

All required form fields *must* be completed to process the claim appeal. If fields are left blank, providers may receive an appeal rejection letter requesting resubmission of a corrected Provider Claim Appeal Form and all supporting documentation.

Provider Information

Provider Name: Enter the provider name.

Service Address, City, State, ZIP Code: Enter the service address for the provider.

National Provider Identifier (NPI) Number: Enter the provider's 10-digit NPI number.

Claim Information

Claim Type: Defaulted to Pharmacy. For claim appeal information for other claim types (e.g., Long Term Care, Inpatient, Outpatient, Medical), visit <https://www.medi-cal.ca.gov/>.

Beneficiary Name: Enter the beneficiary's first and last name.

Beneficiary Medi-Cal ID Number: Enter the beneficiary ID number that appears on the Remittance Advice (RA) showing adjudication of that claim.

Rx Number: Enter the Rx number.

Date of Service: Enter the date of service of the claim in MM/DD/YYYY format.

NDC or Medical Supply Billing Code: Enter the National Drug Code (NDC) or 11-digit NDC-like medical supply billing code. When submitting an appeal for a compound drug claim, enter zero ("0") in place of listing the NDCs, and include each ingredient NDC with the attachment(s).

EOB/RA Code: Enter the Explanation of Benefits (EOB)/Remittance Advice (RA) Code, if applicable.

Number of Attachments: Enter the number of attachments associated with this request.

Total Attachments: Enter the total number of attachments for all requests included on the form.

Appeal Reason

Appeal Reason: Choose the appropriate Appeal Reason and ensure any required supporting documentation is included with your request.

Provider Certification

Signature of Provider or Authorized Representative: The signature of the provider or the provider's authorized representative. An original signature is required; use blue ink.

Print Name: Print the name of the person signing the form.

Date: The date on which the form is signed.

Figure 19.5.1-1: Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)

19.5.2 Tips for Appeal Completion

The following information can be used for completing an appeal.

- Providers must fill out each applicable line completely.
- Do not use ditto marks (""") nor draw an arrow to indicate repetitive information on the form.
- Do not use staples on your paper claims, as staples may delay processing time. Providers may use paper clips.
- All information must be exactly the same as that on the RA (including the Beneficiary Medi-Cal ID Number, Prescription/Rx number, Date of Service, etc.).
- The appeal may contain up to eight claim lines per form, but all lines must be for the same member.
- All supporting documentation must be clear, concise, and complete.
- Failure to complete the Remarks section of the appeal may cause delayed processing.
- Do not use the Remarks section for additional inquiries.
- State clearly and precisely what is being requested in the Remarks section.
- Only original appeals are accepted. Photocopied CIFs will be returned.
- Validate that timeliness requirements are met; refer to [Section 5.2 – Claim Appeal Timeliness](#) for additional information.

Note: Providers submitting improperly completed appeals will receive a *Medi-Cal Rx Appeal Acknowledgement Letter*. The Acknowledgement **will inform** the provider that the appeal is rejected, **identify** what information is missing, and **advise providers** to resubmit a corrected appeal. Providers should include the *Medi-Cal Rx Appeal Acknowledgement Letter* and all other pertinent documentation with the resubmitted appeal. Refer to [Section 5.5 – Acknowledgement of Appeal](#) for additional information on the *Medi-Cal Rx Appeal Acknowledgment Letter*.

19.5.3 Medi-Cal Rx Provider Claim Appeal Packet Checklist

Before mailing an appeal to Medi-Cal Rx, review this checklist to ensure that all pertinent information has been documented and all relevant documentation is attached. All supporting documentation must be legible. Each appeal must contain proof of timeliness.

Note: The checklist is not to be included with the appeal sent to Medi-Cal Rx and should only be used to ensure that all pertinent information is provided.

Mark an ☒ next to all that apply.

- ☐ I have reviewed the *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) and [Section 19.5.1 – Completion Instructions for the Medi-Cal Rx Provider Claim Appeal Form \(DHCS 6571\)](#) for completion instructions.
- ☐ The *Medi-Cal Rx Provider Claim Appeal Form* (DHCS 6571) has been completed in its entirety (be sure to double-check that **all** required fields (identified by a red asterisk [*] have been completed).

- ☐ If the appeal is for a claim that may be an underpayment or overpayment, the "Adjustment Request" box has been checked on the form in *Part 3 – Appeal Reason*.
- ☐ If the appeal is for a claim denial, the reject code from the RA has been entered in the "EOB/RA Code" field on the applicable claim line on the form in *Part 2 – Claim Information*.
- ☐ For an overpayment adjustment because the provider received payment for the claim and the member on the claim is not the provider's patient, complete all applicable required fields and attach only a copy of the paid RA to the *Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)*.
- ☐ Copy of the original claim included or copy of *Medi-Cal Rx Tracer No Hit Letter* included.
- ☐ Corrected claim included (if necessary).
- ☐ If the appeal is for a compound drug claim, include each ingredient NDC with the attachment(s).
- ☐ RAs pertaining to claim history (include only pertinent RA pages).
- ☐ EOMB/MRN included.
- ☐ Prior Authorization request included.
- ☐ OHC payments or denials included.
- ☐ Copy of Point-of-Sale printout or internet eligibility response attached to the claim included.
- ☐ Copy of previously submitted *Medi-Cal Rx Provider Claim Inquiry Form* included.
- ☐ *Medi-Cal Rx Claim Inquiry Acknowledgement Letter* included.
- ☐ *Medi-Cal Rx Claim Inquiry Response Letter* included.
- ☐ All dated correspondence sent to Medi-Cal Rx included.
- ☐ All dated correspondence received from Medi-Cal Rx documenting timely follow-up included.
- ☐ Proof of member eligibility if DOS is over 15 months or last denial was for eligibility included.
- ☐ The *Medi-Cal Rx Provider Claim Appeal Form (DHCS 6571)* has been signed and dated – (All appeals must be signed by the provider or authorized representative for the provider. Appeals submitted without a printed name and signature will be returned to the provider).

19.6 Member Reimbursement Claims

Pursuant to two court decisions, *Conlan v. Bonta* and *Conlan v. Shewry*, DHCS implemented a process which enables Medi-Cal members to obtain reimbursement of paid out-of-pocket expenses for Medi-Cal covered services received during specific periods of a member's Medi-Cal eligibility. These periods include the following:

- Retroactive eligibility period ("Retro"): Up to three months prior to the month the member applies for Medi-Cal Rx benefits (that is, if a member applies on April 1, they are retroactive beginning the previous January 1).
- Evaluation Period ("Eval"): From the date of the member's application until they are issued their BIC ID (that is, if a member completes their application on April 1, and is issued their BIC ID on May 15, they are in the evaluation period between April 1 and May 15).
- Post-Approval Period ("Post"): Any date after the member was issued their BIC ID (that is, if a member is issued their BIC ID on April 1, they are in the post-eligibility period going forward).

In general, members are notified by letter that they may qualify for reimbursement under the terms of the court order.

Members requesting reimbursement for expenses paid out-of-pocket have one year from the DOS to file a reimbursement claim.

19.6.1 CA-MMIS/Gainwell Member Claim Intake Process

To streamline the claim intake process for member reimbursement claim requests, more commonly referred to as "Conlan Claims," CA-MMIS and Gainwell Technologies will provide **all** claim intake services for member reimbursement requests. This includes all member-submitted reimbursement requests for medical, dental, vision and pharmacy. Claims will be handled by CA-MMIS/Gainwell until all required information is submitted and the claim is considered "complete." Once a claim has been deemed as "complete," it will be sent to the Medi-Cal Rx vendor for processing.

19.6.2 Customer Service Center Responsibilities

The CSC is equipped to work with both providers and members to support CA-MMIS/Gainwell with Beneficiary Reimbursement claims (refer to [Section 19.6.1 – CA-MMIS/Gainwell Member Claim Intake Process](#)). Members may contact the CSC (1-800-977-2273) to obtain information and forms for requesting reimbursement.

19.6.3 Provider Notification(s) and Responsibilities

Provider Notification of Member Request for Reimbursement: If a member's request for reimbursement is validated by the CSC, a letter of request for member reimbursement is sent to the provider. The letter must be submitted with the provider's claim for reimbursement.

Provider Responsibilities: Providers, upon receipt of the member reimbursement letter, are expected to reimburse members for expenses the member paid to the provider for a Medi-Cal covered service, then bill Medi-Cal for the same service. Claims will be denied if the member has not been reimbursed. In accordance with the court order to obtain prompt reimbursement to the member, providers that do not comply with the request for member reimbursement are subject, when appropriate, to recoupment action by DHCS of all monies paid to the provider by the member for Medi-Cal covered services.

19.6.4 Claim Submission

Providers must, within sixty days of the date on the member reimbursement letter, submit claims to Medi-Cal as follows:

- Submit an original hard copy claim solely for the services mentioned in the member reimbursement letter.
- Enter delay reason code '10' in the appropriate claim field (refer to [Section 19.3.1 – Submission and Timeliness Instructions](#) for additional information).
- Attach the member reimbursement letter.
- Attach any additional required Medi-Cal documentation.

The original claim, member reimbursement letter, and supporting documentation must be submitted to the Medi-Cal Rx vendor (refer to [Appendix B – Directory](#) for mailing address).

No electronic claim submission is allowed. Because the CSC determines medical necessity, no PA request is required. The six-month billing limit will be modified for these claims.

19.6.5 Reimbursement

The reimbursement rate is the rate on file for the DOS.

Enrollment Requirement

To be reimbursed, the provider must have been enrolled as a Medi-Cal provider on the DOS. Per the instructions on the member reimbursement letter, providers should contact the Medi-Cal Provider Enrollment Division (refer to [Section 2.1 – Enrolling as a Medi-Cal Pharmacy Provider](#)) if any of the following conditions apply:

- The provider was not a Medi-Cal provider on the DOS but wants to enroll now.
- The provider is a Medi-Cal provider now but was not on the DOS and needs retroactive eligibility.
- The provider was not a Medi-Cal provider on the DOS but wants to temporarily enroll retroactively in Medi-Cal in order to bill for the Beneficiary Reimbursement Process claims.

20.0 Medi-Cal Rx Program Integrity

20.1 Program Integrity Plan (PIP) Introduction

The Medi-Cal Rx vendor is committed to its role in preventing and detecting health care Fraud, Waste, and Abuse (FWA). The *Medi-Cal Rx Program Integrity Plan* (PIP) supports the Medi-Cal Rx vendor's commitment to enforce the highest standard of ethics, professional standards, and compliance. The PIP and its standards apply to all employees and members of the Board of Directors, as well as contractors and subcontractors, who must abide by and uphold internal policies, state and federal regulations, Medi-Cal Rx Contract requirements, and external laws that govern Medi-Cal Rx business activities.

The PIP outlines the Medi-Cal Rx vendor's FWA program and mechanism to conduct the following:

- Monitor
- Measure
- Review, validate, refer, and report FWA to DHCS

The Medi-Cal Rx vendor integrates the PIP into all Operational processes to ensure consistent application of FWA controls and reporting. The Medi-Cal Rx vendor is also responsible for engaging the Problem Correction Process (PCP), Change Management, and other external processes. All employees are required to complete training regarding the PIP and attest that the PIP has been read and understood within the first 30 days of hire and annually thereafter.

20.2 What are FWA and Overpayment?

In order to detect FWA, become familiar with what each of these terms mean and understand how to identify potential concerns throughout day-to-day activities.

Fraud – An intentional deception or misrepresentation made by persons with the knowledge that the deception could result in some unauthorized benefit to themselves or some other person and includes any act that constitutes fraud under applicable federal or state law, including 42 CFR Section 455.2 and W&I Code, Section 14043.1.

Waste – The overutilization or inappropriate utilization of services and misuse of resources.

Abuse – Practices that are inconsistent with sound fiscal and business practices or medical standards, and result in an unnecessary cost to Medi-Cal Rx, or in reimbursement for services that are not medically necessary or that fail to meet professional recognized standards of health care. It also includes member practices that result in unnecessary cost to Medi-Cal Rx.

Overpayment – Includes any amount not authorized to be paid by Medi-Cal Rx whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

20.3 Difference Between and Indicators of Potential FWA

There are differences between fraud, waste, and abuse. One of the primary differences is intent and knowledge. **Fraud** requires the person to have the intention to obtain payment and the knowledge that their actions are wrong. **Waste** and **Abuse** may involve obtaining an improper payment but do not require the same intent and knowledge.

Refer to the following examples of how to identify FWA:

Potential Member Issues

- Does the prescription look altered or possibly forged?
- Does the member have multiple prescriptions for the same medication?
- Is the prescription appropriate based on the member's other prescriptions?
- Does the member's medical history support the services being requested?
- Is the member traveling a long distance to get their prescription?
- Does the individual providing the clinical information for the PA appear to have a clinical background?

Potential Provider Issues

- Does the provider write for diverse drugs or primarily only for controlled substances?
- Are the provider's prescriptions appropriate for the member's health condition (medically necessary)?
- Is the provider writing for a higher quantity than medically necessary for the condition?
- Are multiple members of the same family getting the same prescription from the same doctor?

Potential Pharmacy Issues

- Are prescriptions being altered (changing quantities or DAW codes)?
- Are generics provided when the prescription requires that brand be dispensed?
- Are all members receiving the same or similar combinations of drugs?
- Is the pharmacy consistently billing for higher than the recommended dosage?
- Are all of the pharmacy's prescriptions written by one or a few prescribers?
- Is the pharmacy located far away from the patient or prescriber?
- Is the pharmacy using or abusing indicator codes (for example, pregnancy indicator for a male member, emergency indicator codes, etc.)?
- Do all members have the same diagnosis code when a diagnosis code is required?

These sample scenarios may result in member calls, which might include questions such as the following:

- Why did I receive an NOA letter for a denied prescription for a medication that I am not taking?
- Why was my prescription denied for early refill when I have not refilled it?

Individuals calling may wish to remain anonymous and/or are only calling to report suspected FWA. In these situations, provide the Prime Therapeutics Compliance Hotline phone number (1-800-474-8651) and ask to transfer the caller to that number. If they refuse to be transferred, request their contact information; if they refuse to provide it, take down as much information as possible, including any names, dates, locations, or other details of the alleged activity.

20.4 How to Report FWA

Everyone is required to report suspected instances of FWA. Suspected instances must be reported within **one** calendar day. FWA related to Medi-Cal Rx should be reported **immediately** via the Medi-Cal Rx specific FWA Hotline number or the Prime Therapeutics Special Investigations Unit (SIU) email address:

- Toll-free Medi-Cal Rx specific FWA Hotline: 1-800-375-1251, TTY 711
- Prime Therapeutics SIU email address: FraudTipHotline@primetherapeutics.com

For non-Medi-Cal Rx specific FWA or alternative methods of reporting, refer to the following:

- Toll-free Prime Therapeutics SIU Pharmacy FWA Hotline: 1-800-731-3269
- Prime Therapeutics Compliance Hotline for anonymous reporting: 1-800-474-8651
- Prime Therapeutics Compliance Department email address for anonymous reporting: Reports@lighthouse-services.com
- Report suspected instances to Medi-Cal Rx's mailing address:
 - Medi-Cal Rx SIU
11000 White Rock Road
Rancho Cordova, CA 95670
- Report suspected instances to central SIU's mailing address:
 - Prime Therapeutics
Attn: Pharmacy Audit & SIU
2900 Ames Crossing Road
Eagen, MN 55121

21.0 Drug and Product Shortages

The following processes should be used when a provider has determined that a medically necessary drug, medical supply, or enteral nutrition product cannot be acquired from any source in a timely manner.

What Providers Need to Know About Medical Supplies and Enteral Nutrition Products:

- Specific covered products are billed and provided through Medi-Cal Rx as pharmacy-billed benefits.
- Specific products are restricted to the lists on the [Contract Drugs & Covered Products Lists](#) page on the [Medi-Cal Rx Web Portal](#).

- A PA will not override products that are on these lists and restricted to specific NDC/billing codes. Noncontracted products may not be substituted.
- Claims submitted for enteral nutrition products with a DOS through July 1, 2022, qualify for a temporary substitution without the need for a new prescription from the prescriber. This policy will remain in place until the national supply of infant formula stabilizes. DHCS will notify providers and stakeholders no less than 90 days in advance of removing this policy. Product coverage is restricted to the lists on the [Contract Drugs & Covered Products Lists](#) page. For more detailed information, refer to the following resources:
 - [Contract Drugs & Covered Products Lists](#) page on the [Medi-Cal Rx Web Portal](#)
 - [Enteral Nutrition Update: Temporary Interchange of Equivalent Contracted Enteral Nutrition Products Due to Recent Formula Recall](#)
 - [Enteral Nutrition Updates: Interchange of Equivalent Contracted Enteral Nutrition Product and Specialty Infant Authorization Term Limit](#)

What Providers Need to Do to Request Alternative Medical Supplies and Enteral Nutrition Products:

- Providers who encounter out-of-stock products for covered benefits that are specific to a list on the [Contract Drugs & Covered Products Lists](#) page or medical supplies category should immediately contact the CSC at 1-800-977-2273. The CSC is available 24 hours a day, 7 days a week, 365 days per year.
- Providers should have the following information ready:
 - Product NDC/billing code
 - Product name
 - Product category (diabetic test strips, condoms, aerochambers, etc.)
 - Documentation, such as manufacturer documentation or a wholesaler/distributor invoice, demonstrating the product is unavailable from any other source and they have attempted to locate the product
 - Documentation of the alternative product the provider would like to use
 - Provider contact information, Rx number, NPI number, and member information

Prime and DHCS will review the request and respond as soon as administratively possible.

Drug Products

Prior to requesting an alternative, providers must:

1. Confirm that other pharmacies (or locations of a chain pharmacy) in the nearby region are also out of stock and unable to order the requested product.
2. Rule out the use of a suitable alternative that is on the [CDL](#) and available without a PA. This should be done *before* requesting approval of a non-CDL alternative.

Once these conditions have been met, providers should:

1. Submit a PA request noting that the product is unavailable and the request is for an alternative from a CMS-approved manufacturer. Approved products can be located on the [Medi-Cal Rx Approved NDC List](#).
2. Include verification that the CDL alternative is unavailable in the marketplace in the local region where the member resides.
3. Provide supporting documentation (such as wholesaler notification, FDA notification, association bulletin, etc.) confirming there is a shortage, the original product is unavailable, and note the expected duration of the shortage (if known).
4. Only request products from a manufacturer that is not CMS-approved as a last resort when no other options are available.

PA approval may be granted when suitable CDL options are ruled out.

An emergency supply of the alternative medication may be dispensed immediately to the member for up to a 14-day supply. Such a dispensing does not require a PA. If the shortage is expected to be long term, or there is risk of initially providing the emergency product and subsequently switching to a CDL alternative after the emergency supply runs out (for example, destabilization of the condition), then a PA for extended use of the alternative product should be submitted in a timely manner so it can be adjudicated prior to the emergency supply running out.

22.0 Discontinued Product NDCs

Medi-Cal Rx utilizes First Databank (FDB) as its primary source for drug information. Manufacturers are responsible for providing FDB with all the information regarding their products as well as if the product has been discontinued. Claims submitted to Medi-Cal Rx in which the manufacturer has reported the NDC as discontinued will deny with Reject Code 77 – Discontinued Product/Service ID Number.

Pharmacy providers receiving a denied claim with Reject Code 77 should resubmit claims using an alternate NDC for the product that has not been discontinued by the manufacturer. If no alternate NDC is available for the product, pharmacy providers may submit a PA request for the discontinued NDC.

Prior to submitting a PA request, providers must:

1. Rule out the use of suitable NDC alternatives that are on the [Medi-Cal Rx Approved NDC List](#) for the product that are CMS-authorized drug manufacturer labelers.
2. Rule out the use of suitable NDC alternatives for the product that are not CMS-authorized drug manufacturer labelers.
3. Confirm that other pharmacies (or locations of a chain pharmacy) in the nearby region are also unable to dispense the requested product for an NDC that does not deny with Reject Code 77.
4. Confirm the product has not been discontinued by the manufacturer.
5. Confirm the product NDC has not passed the expiration date on the manufacturer bottle.

Once these conditions have been met, providers should:

1. Submit a PA request noting that the request is for a discontinued NDC and the claim is denying with Reject Code 77.
2. Include verification that all alternate products and NDCs have been considered and cannot be used for dispensing, and alternate NDCs are unavailable in the local region where the member resides.
3. Provide supporting documentation (such as wholesaler notification, manufacturer notification, etc.) confirming the product has not been discontinued and the product NDC has not passed its expiration date.
4. Provide supporting clinical rationale or documentation establishing medical necessity for coverage considerations of the product.

Notes:

- Requests submitted for a DOS in the past (backdated) for NDCs denying with Reject Code 77 will be denied.
- Requests submitted for NDCs denying with Reject Code 77 in which these conditions are not met will be denied.
- Requests submitted for NDCs denying with Reject Code 77 in which these conditions are met are also subject to subsequent Medi-Cal Rx UM claim edits. Providers will be required to include clinical rationale establishing medical necessity for coverage considerations of the product in the PA request.

23.0 Acronyms

Acronym/Term	Definition
AA	Actual Age
AAC	Actual Acquisition Cost
AB	Assembly Bill
ADAP	AIDS Drug Assistance Program
AEVS	Automated Eligibility Verification System
ARPA	American Rescue Plan Act
ASP	Average Sales Price
AWP	Average Wholesale Price
BIC	Benefits Identification Card
BMN	Brand Medically Necessary
BOP	Board of Pharmacy
CA	Corrected Age
CCR	California Code of Regulations
CCS	California Children's Services
CDC	Centers for Disease Control and Prevention
CDL	Contract Drugs List
CDM	Clinical Decision Module
CFR	Code of Federal Regulations
CGM	Continuous Glucose Monitoring
CHDP	Child Health and Disability Prevention
CIF	Claim Inquiry Form
CIN	Client Index Number
CMPA	Cow's Milk Protein Allergy
CMS	Centers for Medicare & Medicaid Services
COB	Coordination of Benefits
COV	Scope of Coverage
CPT	Current Procedural Terminology
CSC	Customer Service Center
CSR	Customer Service Representative

Acronym/Term	Definition
DAW	Dispense as Written
DBA	Doing Business As
DCN	Document Control Number
DEA	Drug Enforcement Administration
DHCS	Department of Health Care Services
DIDD	Disposable Insulin Delivery Device(s)
DME	Durable Medical Equipment
DOS	Date of Service
DUR	Drug Use Review
EAC	Estimated Acquisition Cost
EFT	Electronic Funds Transfer
EH	Extensively Hydrolyzed
EIN	Employee Identification Number
EMR	Electronic Medical Record
EOB	Explanation of Benefits
EOMB	Explanation of Medicare Benefits
ePA	Electronic Prior Authorization
EPSDT	Early Periodic Screening, Diagnosis, and Treatment
ERA	Electronic Remittance Advices
EUA	Emergency Use Authorization
FAQ	Frequently Asked Questions
FD&C Act	Federal Food, Drug and Cosmetic Act
FFS	Fee-for-Service
FI	Fiscal Intermediary
FPACT	Family Planning, Access, Care, and Treatment
FTP	File Transfer Protocol
FUL	Federal Upper Limit
FWA	Fraud, Waste, and Abuse
GAD	Gross Amount Due
GHPP	Genetically Handicapped Persons Program
HAP	Health Access Programs

Acronym/Term	Definition
HbA1c	Hemoglobin A1c
HCPCS	Healthcare Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act
HMO	Health Maintenance Organization
HTC	Hemophilia Treatment Center
ICD-10-CM	International Classification of Diseases – 10 th Revision – Clinical Modification
ICF/DD	Intermediate Care Facility for the Developmentally Disabled
ICF/DD-H	Intermediate Care Facility for the Developmentally Disabled/Habilitative
ICF/DD-N	Intermediate Care Facility for the Developmentally Disabled/Nursing
ID	Identification
IEM	Inborn Errors of Metabolism
IRS	Internal Revenue Service
I.V.	Intravenous
LCHAD	Long-chain-3-hydroxyacyl-CoA-dehydrogenase
LOA	Letter of Authorization
LTC	Long Term Care
MAC	Maximum Allowable Cost
MAIC	Maximum Allowable Ingredient Cost
MAPC	Maximum Allowable Product Cost
MCP	Managed Care Plan
MEDS	Medi-Cal Eligibility Data System
MME	Morphine Milligram Equivalents
MRN	Medicare Remittance Notice
NADAC	National Average Drug Acquisition Cost
NCPDP	National Council for Prescription Drug Programs
NDC	National Drug Codes
NOA	Notice of Action
NPI	National Provider Identifier

Acronym/Term	Definition
OCC	Other Coverage Code
OHC	Other Health Coverage
OOP	Out of Pocket
ORP	Ordering, Referring, and Prescribing
OTC	Over-the-Counter
P/DCL	Procedure/Drug Code Limitation
PA	Prior Authorization
PACE	Programs of All-Inclusive Care for the Elderly
PAD	Physician Administered Drug
PATC	Prior Authorization Type Code
PAVE	Provider Application and Validation for Enrollment
PCN	Processor Control Number
PCP	Problem Correction Process
PED	Provider Enrollment Division
PHE	Public Health Emergency
PI/SIU	Program Integrity/Special Investigations Unit
PIN	Provider Identification Number
PIP	Program Integrity Plan
PMF	Provider Master File
POS	Point of Sale
Prime	Prime Therapeutics State Government Solutions LLC
ProDUR	Prospective Drug Use Review
RA	Remittance Advice
RetroDUR	Retrospective Drug Use Review
ROA	Route of Administration
S&I	Suspended and Ineligible Provider List
SCAN	Senior Care Action Network
SCC	Submission Clarification Code
SIU	Special Investigations Unit
SNOMED	Systematized Nomenclature of Medicine
SOC	Share of Cost

Acronym/Term	Definition
SSN	Social Security Number
STI	Sexually Transmitted Infection
TCN	TAR Control Number
TIN	Taxpayer Identification Number
TPN	Total Parenteral Nutrition
U&C	Usual and Customary
UAC	User Administration Console
UCF	Universal Claim Form
UM	Utilization Management
UOM	Unit of Measure
UPC	Universal Product Code
UPN	Universal Product Number
US	United States
VA	Veteran's Administration
VFC	Vaccines For Children
W&I Code	Welfare and Institutions Code
WAC	Wholesale Acquisition Cost
WCS	Web Claims Submission

24.0 Appendices

Appendix A – NCPDP Payer Specification Sheet

To access the *NCPDP Payer Specification Sheet* for Medi-Cal Rx, click [here](#).

Appendix B – Directory

To access the Medi-Cal Rx Directory, click [here](#).

Appendix C – Aid Codes

To access the Aid Codes list, click [here](#).

Appendix D – NCPDP Reject Codes

To access the NCPDP Reject Codes list, click [here](#).

Appendix E – Acceptable Medi-Cal Rx PA Request Forms

Medi-Cal Rx PA Request Form (preferred)

The [Medi-Cal Rx Prior Authorization Request Form \(DHCS 6560\)](#) can be found on the [Medi-Cal Rx Provider Portal](#) by selecting [Forms & Information](#).

Alternate PA request forms that may be accepted by Medi-Cal Rx are forms 50-1, 50-2, and 61-211, as shown below:

Medi-Cal Form 50-1

STATE
USE
ONLY

1

5

TYPewriter ALIGNMENT

Elke Pica

CONFIDENTIAL PATIENT INFORMATION

FOR F.I. USE ONLY

1A

CCN

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES

FI USE ONLY

40 41 42 43

TYPewriter ALIGNMENT

Elke Pica

43

(PLEASE TYPE)

VERBAL CONTROL NO. 1B

2

TYPE OF SERVICE REQUESTED

3. PROVIDER NUMBER

PROVIDER NAME AND ADDRESS

2B

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, MI.) 4

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER: AREA ()

DIAGNOSIS DESCRIPTION:

MEDICAL JUSTIFICATION: 8C

9

FOR PROVIDER USE

REQUEST IS RETROACTIVE? YES NO

IS PATIENT MED-CARE ELIGIBLE? YES NO

PROVIDER PHONE NO. 2A

55 27

5

6

SEX AGE DATE OF BIRTH 7 8

PATIENT STATUS: HOME BOARD & CARE 8A

SNF / ICF ACUTE HOSPITAL 8B

100-9-CM DIAGNOSIS CODE

(PLEASE TYPE)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY) ENTER NAME AND ADDRESS:

32A

33

FOR STATE USE

34 PROVIDER, YOUR REQUEST IS:

1 ☐ APPROVED AS REQUESTED ☐ DENIED ☐ DEFERRED

2 ☐ APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) ☐ JACKSON VS RANK PARAGRAPH CODE

BY: MEDICAL CONSULTANT DATE

34 35 36 37 38 39

COMMENTS/EXPLANATION

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 5190 (b)

36

LINE NO.	APPROVED Y/N	APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	NDC/UPN OR PROCEDURE CODE	QUANTITY	CHARGES
1	<input type="checkbox"/>	<input type="checkbox"/>	10 10A	10B	11	12	12A
2	<input type="checkbox"/>	<input type="checkbox"/>					
3	<input type="checkbox"/>	<input type="checkbox"/>					
4	<input type="checkbox"/>	<input type="checkbox"/>					
5	<input type="checkbox"/>	<input type="checkbox"/>					
6	<input type="checkbox"/>	<input type="checkbox"/>					

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

39A

SIGNATURE OF PHYSICIAN OR PROVIDER TITLE DATE

37 THORIZATION IS VALID FOR SERVICES PROVIDED FROM DATE TO DATE

38

TAR CONTROL NUMBER

39 OFFICE SEQUENCE NUMBER PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE.

PROVIDER COPY

50-1 03/97

Medi-Cal Form 50-2

STATE
USE
ONLY

SERVICE
CATEGORY

4

CONFIDENTIAL **PATIENT INFORMATION**

FOR F.I. USE ONLY

CCN

TREATMENT AUTHORIZATION REQUEST

STATE OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES

F.I. USE ONLY

40 ☐ 41 ☐

42 ☐ 43 ☐

(PLEASE TYPE)

VERBAL CONTROL NO.

TYPE OF SERVICE REQUESTED: ☐ DRUG ☐ OTHER

REQUEST IS RETROACTIVE? ☐ YES ☐ NO

IS PATIENT MEDICARE ELIGIBLE? ☐ YES ☐ NO

PROVIDER PHONE NO.

(PLEASE TYPE)

PATIENT'S AUTHORIZED REPRESENTATIVE (IF ANY)
ENTER NAME AND ADDRESS:

•

•

•

3. PROVIDER NUMBER

PROVIDER NAME AND ADDRESS

•

•

•

•

•

NAME AND ADDRESS OF PATIENT

PATIENT NAME (LAST, FIRST, M.I.)

STREET ADDRESS

CITY, STATE, ZIP CODE

PHONE NUMBER (AREA)

MEDI-CAL IDENTIFICATION NO.

SEX AGE DATE OF BIRTH

PATIENT STATUS: ☐ HOME ☐ BOARD & CARE ☐ SNF / ICF ☐ ACUTE HOSPITAL

DIAGNOSIS DESCRIPTION:

MEDICAL JUSTIFICATION:

33 PROVIDER: YOUR REQUEST IS:

☐ APPROVED AS REQUESTED ☐ DENIED ☐ DEFERRED

☐ APPROVED AS MODIFIED (ITEMS MARKED BELOW AS AUTHORIZED MAY BE CLAIMED) ☐ JACKSON VS RANK PARAGRAPH CODE

BY I.D. # MEDIC-AL CONSULTANT DATE REVIEW COMPLETION INDICATOR

34 35 36 37 38 39 40

COMMENTS/EXPLANATION:

RETROACTIVE AUTHORIZATION GRANTED IN ACCORDANCE WITH SECTION 51003 (b)

41 ☐ 42 ☐ 43 ☐ 44 ☐ 45 ☐ 46 ☐

LINE NO.	AUTHORIZED		APPROVED UNITS	SPECIFIC SERVICES REQUESTED	UNITS OF SERVICE	HDC/UPC OR PROCEDURE CODE	QUANTITY	CHARGES
	YES	NO						
1	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					\$ <input type="text"/>
2	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					\$ <input type="text"/>
3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					\$ <input type="text"/>
4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					\$ <input type="text"/>
5	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					\$ <input type="text"/>
6	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					\$ <input type="text"/>

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS TRUE, ACCURATE AND COMPLETE AND THE REQUESTED SERVICES ARE MEDICALLY INDICATED AND NECESSARY TO THE HEALTH OF THE PATIENT.

SIGNATURE OF PHYSICIAN OR PROVIDER

TITLE

DATE

AUTHORIZATION IS VALID FOR SERVICES PROVIDED

37 FROM DATE 38 TO DATE

TAR CONTROL NUMBER

39 OFFICE SEQUENCE NUMBER **40699748** PI

NOTE: AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. BE SURE THE PATIENT'S ELIGIBILITY IS CURRENT BEFORE RENDERING SERVICE. SEND TO FIELD SERVICES (F.I. COPY)

50-2 06/93
SEE YOUR PROVIDER MANUAL FOR ASSISTANCE REGARDING THE COMPLETION OF THIS FORM.

PRESCRIPTION DRUG PRIOR AUTHORIZATION OR STEP THERAPY EXCEPTION REQUEST FORM

Plan/Medical Group Name: _____ Plan/Medical Group Phone#: (_____) _____
 Plan/Medical Group Fax#: (_____) _____ Non-Urgent ☐ Exigent Circumstances ☐

Instructions: Please fill out all applicable sections on both pages completely and legibly. Attach any additional documentation that is important for the review, e.g. chart notes or lab data, to support the prior authorization or step-therapy exception request. Information contained in this form is Protected Health Information under HIPAA.

Patient Information				
First Name:	Last Name:	MI:	Phone Number:	
Address:		City:	State:	Zip Code:
Date of Birth:	<input type="checkbox"/> Male <input type="checkbox"/> Female	Circle unit of measure Height (in/cm): _____ Weight (lb/kg): _____	Allergies:	
Patient's Authorized Representative (if applicable):			Authorized Representative Phone Number:	
Insurance Information				
Primary Insurance Name:			Patient ID Number:	
Secondary Insurance Name:			Patient ID Number:	
Prescriber Information				
First Name:	Last Name:		Specialty:	
Address:		City:	State:	Zip Code:
Requestor (if different than prescriber):			Office Contact Person:	
NPI Number (individual):			Phone Number:	
DEA Number (if required):			Fax Number (in HIPAA compliant area):	
Email Address:				
Medication / Medical and Dispensing Information				
Medication Name:				
<input type="checkbox"/> New Therapy <input type="checkbox"/> Renewal <input type="checkbox"/> Step Therapy Exception Request If Renewal: Date Therapy Initiated: _____ Duration of Therapy (specific dates): _____				
How did the patient receive the medication?				
<input type="checkbox"/> Paid under Insurance Name: _____ Prior Auth Number (if known): _____ <input type="checkbox"/> Other (explain): _____				
Dose/Strength:	Frequency:	Length of Therapy/#Refills:	Quantity:	
Administration:				
<input type="checkbox"/> Oral/SL <input type="checkbox"/> Topical <input type="checkbox"/> Injection <input type="checkbox"/> IV <input type="checkbox"/> Other: _____				
Administration Location:				
<input type="checkbox"/> Patient's Home <input type="checkbox"/> Long Term Care <input type="checkbox"/> Physician's Office <input type="checkbox"/> Home Care Agency <input type="checkbox"/> Other (explain): _____ <input type="checkbox"/> Ambulatory Infusion Center <input type="checkbox"/> Outpatient Hospital Care _____				

Appendix F – P/DCL Provider Limitation List

To access the P/DCL Provider Limitation List, click [here](#).

Appendix G – OHC Carrier Information

To access contact and payer information on OHC carriers pertaining to drug-related coverage, click [here](#).